

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

THERAPY - INCIDENT TO

Please see attached file

Via Electronic Mail -- <http://www.cms.hhs.gov/regulations/ecomments>

Jason C. Halverson MA,  
ATC/L, CSCS  
1305 Village Lane  
Bolivar, MO 65613

Attachment to #1100

9/9/04

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1429-P  
P.O. Box 8012  
Baltimore, MD 21244-8012

Re: Therapy – Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of “incident to” services in physician clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

During the decision-making process, please consider the following:

- Incident to has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician’s professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician’s choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient.
- There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY incident to service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. It is imperative that physicians continue to make decisions in the best interests of the patients.
- In many cases, the change to “incident to” services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly

accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient.

- This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working “incident to” the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.
- Patients who would now be referred outside of the physician’s office would incur delays of access. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Delays would hinder the patient’s recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.
- Curtailing to whom the physician can delegate “incident to” procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, who are already too busy, will take away from the physician’s ability to provide the best possible patient care.
- To allow only physical therapists and PT assistants, occupational therapists and OT assistants, and speech and language pathologists to provide “incident to” services would improperly provide those groups exclusive rights to Medicare reimbursement. To mandate that only those practitioners may provide “incident to” care in physicians’ offices would improperly remove the states’ right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.
- CMS, in proposing this change, offers no evidence that there is a problem that is need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.
- CMS does not have the statutory authority to restrict who can and cannot provide services “incident to” a physician office visit. In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of physical therapy services.
- Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists.
- Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to prevent, assess, treat and rehabilitate injuries sustained during athletic competition. In addition, dozens of athletic trainers will be accompanying the U.S. Olympic Team to Athens, Greece this summer to provide these services to the top athletes from the United States. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of running in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified.

- These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,

Jason C. Halverson MA, ATC/L, CSCS

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

THERAPY - INCIDENT TO

I am writing to say how unhappy I am with this newly revised purposal. I am a Certified Athletic Trainer. We have extensive training in physical therapy, and more over, a vast back ground in emergency care. It is absurd to pupose we should not be able to treat medicare patients. Look into the schooling of a Certified Athletic Trainer. Then, and only then, will you realize how unfair this would be to a Medicare patient. You are taking away a highly qualified medical care practitioner's ability to treat them. I strongly urge you to look very carefully into this purposal. Why would Certified Athletic Trainer's not be allowed to treat these Medicare patients and Physical Therpiest can? As a qualified medical care professional I can only beg you to turn down this purposal. It is the only right decision to make. Thank you.

Donna Grech B.S. A.T.C

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

THERAPY - INCIDENT TO

Please see attached file!

Aaron Wolfe, ATC  
Sports Medicine Coordinator  
Physical Therapy Consultants, Inc.  
Head Athletic Trainer  
St. Francis High School  
3220 Bridge Street Suite 111  
St. Francis, MN 55070

September 9, 2004  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1429-P  
P.O. Box 8012  
Baltimore, MD 21244-8012

Re: Therapy - Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of **"incident to"** services in physician offices and clinics. If adopted, this would eliminate the ability of qualified health care professionals like myself, *"a Certified and Licensed Athletic Trainer (R/AT, A.T.,C), to provide these important services"*. In turn, it would reduce the quality of health care for our Medicare patients in our clinics due to, decreased availability in our PT's schedule because an ATC would not be allowed to see patients to open up that PT's schedule and ultimately increase the costs associated with this service placing an undue burden on the health care system.

During the decision-making process, please consider the following:

· **1 "Incident to"** has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician's professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician's choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient.

· **2** There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY "incident to" service. *"Because the physician accepts legal responsibility for the individual(s) under his or her supervision along with each states medical board (43 states so far) which require licensure for all Athletic Trainers, and also require as part of the licensure process, that policies and procedures be developed, and signed by the over-looking physician"* , **it is imperative that physicians continue to make decisions in the best interests of the patients.**

Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service.

· **3** In many cases, the change to "incident to" services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient.

- 4 This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working "incident to" the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.
- 5 Patients who would now be referred outside of the physician's office would incur delays of access. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Delays would hinder the patient's recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.
- 6 Curtailing to whom the physician can delegate "incident to" procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, who are already too busy, will take away from the physician's ability to provide the best possible patient care.
- 7 Athletic trainers are highly educated. **ALL** certified and licensed athletic trainers **must have a bachelor's or master's degree** from an accredited college or university. Foundation courses include: human physiology, human anatomy, kinesiology/biomechanics, nutrition, acute care of injury and illness, statistics and research design, and exercise physiology. Seventy (70) percent of all athletic trainers have a master's degree or higher. This great majority of practitioners who hold advanced degrees are comparable to other health care professionals, including physical therapists, occupational therapists, registered nurses, speech therapists and many other mid-level health care practitioners. . *"I have a B.A. Degree and double majored in Athletic Training and Exercise Science and my clinical experience was 5 years long not 2 years like other comparable practitioners in the health care field"*. Academic programs are accredited through an independent process by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) via the Joint Review Committee on educational programs in Athletic Training (JRC-AT).
- 8 To allow *only* physical therapists, occupational therapists, and speech and language pathologists to provide "incident to" outpatient therapy services would improperly provide these groups exclusive rights to Medicare reimbursement. To mandate that only these practitioners may provide "incident to" outpatient therapy in physicians' offices would improperly remove the states' right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.
- 9 CMS, in proposing this change, offers no evidence that there is a problem that is in need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.
- 10 CMS does not have the statutory authority to restrict who can and cannot provide services "incident to" a physician office visit. ***In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of therapy services.***
- 11 Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists.
- 12 Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to **prevent, evaluate, treat and rehabilitate** injuries sustained during athletic competition. In addition, dozens of athletic trainers will be accompanying the U.S. Olympic Team to Athens, Greece this summer to provide these services to the top athletes from the United States. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result

of walking in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified.

· **13** These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,

Aaron Wolfe, R/AT, A.T.,C

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

THERAPY - INCIDENT TO

Please see attached file

Kevin Messey MS, ATC  
University of Cal, San Diego  
9500 Gilman Dr.  
ICA 0531  
La Jolla, CA 92093



September 9, 2004

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1429-P  
P.O. Box 8012  
Baltimore, MD 21244-8012

Re: Therapy – Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of “incident to” services in physician clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

During the decision-making process, please consider the following:

- Incident to has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician’s professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician’s choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient.
- There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY incident to service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. It is imperative that physicians continue to make decisions in the best interests of the patients.
- In many cases, the change to “incident to” services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient.
- This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working “incident to” the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.
- Patients who would now be referred outside of the physician’s office would incur

- delays of access. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Delays would hinder the patient's recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.
- Curtailing to whom the physician can delegate "incident to" procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, who are already too busy, will take away from the physician's ability to provide the best possible patient care.
  - To allow only physical therapists and PT assistants, occupational therapists and OT assistants, and speech and language pathologists to provide "incident to" services would improperly provide those groups exclusive rights to Medicare reimbursement. To mandate that only those practitioners may provide "incident to" care in physicians' offices would improperly remove the states' right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.
  - CMS, in proposing this change, offers no evidence that there is a problem that is need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.
  - CMS does not have the statutory authority to restrict who can and cannot provide services "incident to" a physician office visit. In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of physical therapy services.
  - Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists.
  - Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to prevent, assess, treat and rehabilitate injuries sustained during athletic competition. In addition, dozens of athletic trainers will be accompanying the U.S. Olympic Team to Athens, Greece this summer to provide these services to the top athletes from the United States. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of running in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified.
  - These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,

Kevin Messey MS, ATC  
University of California San Diego  
9500 Gilman Dr.  
ICA 0531  
La Jolla, CA 92093

Submitter : Mrs. Dawn Hammerschmidt Date & Time: 09/09/2004 06:09:45

Organization : Minnesota State University Moorhead

Category : Other Health Care Professional

Issue Areas/Comments

**GENERAL**

GENERAL

RE: Therapy - Incident To

September 9, 2004

Dawn Hammerschmidt, M.Ed., ATC/R  
Assistant Professor  
Health & Physical Education Department  
Minnesota State University Moorhead

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1429-P  
P.O. Box 8012  
Baltimore, MD 21244-8012

Dear Sir/Madam:

As a Certified Athletic Trainer and possible future patient, I feel compelled to write this letter in opposition of proposal CMS-1429-P. As an educator of future Athletic Trainers, I am concerned that this proposal would limit patient access to qualified health care providers of "incident to" services, such as ATC's in physician offices and clinics; thereby reducing the quality of health care for physically active patients. Furthermore, limiting access to qualified health care providers will cause delays in the delivery of quality health care, which in turn will increase health care costs and tax an already heavily burdened health care system.

Athletic Training is a health care profession that specializes in the prevention, assessment, treatment and rehabilitation of injures to athletes and others engaged in physical activities. Athletic trainers are multi-skilled health care professionals who can, and are, making significant contributions to health care. Athletic trainers are highly educated and fully qualified health care providers, evident in thier recognition by the American MEDical Association as an allied helath care profession. If this proposal were to pass, it would threaten the employment of many Certified Athletics Trainers currently employed as physician extenders in clinics and physician offices. The proposal threatens the future of students enrolled in Athletic Training Education Programs throughout the United States. With this type of limitation artificially placed on the provision of "incident to" services by qualified (through accredited academic programs in athletic training, a national board examination, and state practice acts) health care providers the CMS will only add to the skyrocketing health care costs, put qualified people out of work, and reduce the overall qaulity of health care in the United States.

In conclusion, I believe that the CMS-1429-P proposal must be rejected in order to protect the rights (the right to choose and the right for quality care) of our patients and my right as a health care practioner.

Sincerely,

Dawn Hammerschmidt

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

THERAPY - INCIDENT TO

Please see attached file

Via Electronic Mail -- <http://www.cms.hhs.gov/regulations/ecomments>

Barrie Steele, MS, LAT, ATC  
University of Idaho  
124 Kibbie Activity Center  
Moscow, ID 83844-2302

September 15, 2004

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1429-P  
P.O. Box 8012  
Baltimore, MD 21244-8012

Re: Therapy – Incident To

Dear Sir/Madam:

I am writing in response to the recent proposal that would limit providers of “incident to” services in physician clinics. This proposal, if adopted, would be detrimental to our health care system and would reduce the quality of care received by Medicare patients.

For the past 19 years I have worked as head athletic trainer at the University of Idaho, providing quality health care for hundreds of elite athletes. Many of these individuals have gone on to pursue careers in professional sports, and have come to rely on the outstanding care of certified athletic trainers throughout their adult lives. To imply that I am not qualified to provide this same level of service to our active, senior athletes is insulting. To deny our senior population access to qualified health care providers would be unfortunate, and could cause a host of problems.

The United States is experiencing a shortage of qualified health care providers. Restricting providers of incident to services would exacerbate this shortage by eliminating quality providers of these important services. In turn, it would reduce the quality of health care for our Medicare patients, increase the costs associated with this service and place an undue burden on the health care system.

Physicians have utilized “incident to” to provide services to patients since the inception of the Medicare program in 1965. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician’s choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient.

There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY incident to service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. *It is imperative that physicians continue to make decisions in the best interests of the patients.*

Certified athletic trainers work under the direct supervision of a physician and operate as part of the total health care team. My colleagues are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to **prevent, assess, treat and rehabilitate** injuries sustained during athletic competition. Dozens of athletic trainers accompanied the U.S. Olympic Team to Athens, Greece to provide these services to the top athletes from the United States. In addition, many more will provide services to participants during the upcoming Senior Olympic Games. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of running in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent. Thank you for considering my comments.

Sincerely,

Barrie Steele, MS, LAT, ATC  
Head Athletic Trainer  
University of Idaho

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

THERAPY - INCIDENT TO

Athletic Trainer are educated in a four-year accredited school/program to be qualified to perform accurate services to patients in clinic settings, etc. I don't understand how it would be possible for P.T. or P.T.A. to perform the same services as an Athletic Trainer.

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

DIAGNOSTIC PSYCHOLOGICAL TESTS

The American Psychological Association has long maintained that psychologists have the greatest level of expertise in testing and therefore are the best qualified to supervise others performing such tests.

As a licensed psychologist I strongly support the proposed rule change.

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

THERAPY - INCIDENT TO

Please do not pass this proposal. The certified athletic trainer is a very skilled health care provider and deserves to be incident to billing. This proposal has not examined the importance of the athletic trainer to the physically active and their billing rights.  
Please defeat this proposal.

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

DIAGNOSTIC PSYCHOLOGICAL TESTS

I strongly urge that doctoral level psychologists be given the authority to independently supervise unlicensed psychometricians or other appropriately trained testing technicians (e.g., doctoral students) in both inpatient and outpatient settings so that such services can be made available to larger numbers of patients in more cost-effective ways than occurs if psychologists are not allowed such supervisory authority (which results in a more limited number of patients being served either because the psychologist has to perform the testing him or herself, which can be quite time-consuming, or the clinician decides not to provide such services at all because of time and cost issues). The extensive academic and supervised training that is required to obtain a Ph.D. in clinical psychology and to obtain state licensure in the field certainly equals the amount of training earned by medical doctors in their fields of specialization, and as such should afford clinical psychologists the same degree of control and authority over the work they undertake (with or without testing technicians) as a physician has over the individuals working under him or her. Finally, very few medical doctors have the training necessary to even minimally supervise psychological testing procedures, and thus, should not be identified as necessary for the authorization of testing by a technician, who is working for a licensed clinical psychologist.

Submitter :  Date & Time:

Organization :

Category :

Issue Areas/Comments

**GENERAL**

GENERAL

September 2004

Center for Medicare & Medicaid Services  
Department of Health & Human Services  
Attention CMS 1429-P  
P.O. Box 8012  
Baltimore, MD 21244-8012

CMS Code 1429-P

I am writing to comment on the Proposed Rules governing the Physician Fee Schedule for Calendar Year 2005 as printed in the Federal Register of August 5, 2004.

I object to the Proposed Geographic Practice Cost Indices for 2005 because they fail to correct proven inadequacies in reimbursements to localities currently categorized as "Locality 99" that exceed the 5 percent threshold (the "105% rule") over the national 1.000 average. Specifically, the new GPCIs exacerbate reimbursement deficiencies for the California counties of Santa Cruz, Sonoma, Monterey, San Diego, Sacramento, Santa Barbara and El Dorado.

In particular, the county of Santa Cruz, when broken out from Locality 99, would otherwise reflect a 1.125 percent GAF - higher than the California Localities 17 (Ventura), 18 (Los Angeles) and 26 (Orange). The boundary payment difference between Santa Cruz County and its neighboring county of Santa Clara (Locality 9) is a whopping 25.1 percent. Such statistics demonstrate the fallacy of the GPCI formula and demand CMS develop either exceptions to the current rules that would correct for the Santa Cruz situation or refine the formula to more accurately reflect the true cost of medical practitioners. Not to do so perpetuates an inherently unfair and discriminatory formula.

In its August 5 notice, CMS states that on the issue of payment localities "[a]ny policy that we would propose would have to apply to all States and payment localities." Such an effort is commendable and bespeaks a desire to be fair to all physicians across the nation. However, the reality is that the governing statute does not prohibit individual State fixes or individual county or locality fixes. The CMS is not constrained by law from developing a strategy - with or without the concurrence of the state medical association - to correct the discrepancies in the reimbursement levels to California counties and I request that it do so as part of this rulemaking process.

CMS cannot postpone a solution this year as it did last year. Failure to address the GPCI/locality issue in California only grows the problems and will make fixing it all the more difficult in the future. Further, it threatens to undermine medical care to Medicare beneficiaries. Evidence from the local medical society shows an increasing trend toward doctors refusing to accept new Medicare patients. Many doctors are simply leaving the county to practice elsewhere, depleting the county of its medical resources. To implement the August 5 proposed rules would be counterproductive to CMS' mission to make Medicare benefits affordable and accessible to America's seniors.

I object to the Proposed Geographic Practice Cost Indices for 2005 as printed in the Federal Register of August 5, 2004. I request that CMS define

a method in which it can revise the GPCIs for those California counties - especially Santa Cruz - that exceed 5 percent of the national average and begin reimbursing doctors in those counties more appropriate to their true costs.

Sincerely,

Vaal P Rothman M.D.

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

THERAPY - INCIDENT TO

I am very concerned about the issue concerning excluding the athletic trainer from reimbursement for services provided relating to health care and rehabilitation. If anyone is qualified to work with patients and provide excellent and appropriate health care to those who have suffered a musculoskeletal-related injury, it would be the certified athletic trainer (ATC). I consider the ATC to be more important than a physical therapist, (or any other health care specialist), for treating and/or rehabilitating musculoskeletal-related injuries and/or other related injuries. We must not be prevented from receiving appropriate payment for our services, nor be limited in our ability to provide the services for which we are qualified.

Sincerely,  
A Very Concerned Athletic Trainer,  
David L. Butterfield, MS, ATC, LAT  
Parkland High School  
El Paso, TX 79924  
(915) 434-6024 (WORK)

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

THERAPY - INCIDENT TO

Athletic Trainers complete a four-year program to be certified to provide services to athletes in a clinical setting. How is it that they can't file medicare/medicaid and a P.T. or an assistant P.T. who only complete a two-year program could file when performing the the same capacity as an Athletic Trainer?

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

THERAPY - INCIDENT TO

Please see attached file



**DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE AND MEDICAID SERVICES  
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS**

Please note: The attachment cited in this document is not included for one of the following reasons:

1. Improper format.
2. The submitter did not follow through when attaching the document.
3. The submitter had intended to attach more than one, but not all attachments were received.
4. The type of document provided was a password-protected file. CMS was given read-only access to the document.

We cannot provide this electronic attachment to you at this time, but you would like to view any of those that are not posted on this web site, you may call CMS and schedule an appointment at **1-800-743-3951**. Those comments along with its attachment(s), that could not be posted, will be available for your viewing at that time.

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

THERAPY - INCIDENT TO

Please see attached file.

Suzi Eisenhauer  
206 North Pine  
Tonkawa, OK 74653

September 9, 2004

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1429-P  
P.O. Box 8012  
Baltimore, MD 21244-8012

Re: Therapy – Incident To

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I am writing to express my concern over the recent proposal that would limit providers of "incident to" services in physician clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

During the decision-making process, please consider the following:

- Incident to has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician's professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician's choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient.
- There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY incident to service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. It is imperative that physicians continue to make decisions in the best interests of the patients.
- In many cases, the change to "incident to" services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient.
- This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working "incident to" the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.
- Patients who would now be referred outside of the physician's office would incur delays of access. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Delays would hinder the patient's recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.
- Curtailing to whom the physician can delegate "incident to" procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, who are already too busy, will take away from the physician's ability to provide the best possible patient care.
- To allow only physical therapists and PT assistants, occupational therapists and OT assistants, and speech and language pathologists to provide "incident to" services would improperly provide those groups exclusive rights to Medicare reimbursement. To mandate that only those practitioners may provide "incident to" care in physicians' offices would improperly remove the states' right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.

- CMS, in proposing this change, offers no evidence that there is a problem that is need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.
- CMS does not have the statutory authority to restrict who can and cannot provide services "incident to" a physician office visit. In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of physical therapy services.
- Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists.
- Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to prevent, assess, treat and rehabilitate injuries sustained during athletic competition. In addition, dozens of athletic trainers will be accompanying the U.S. Olympic Team to Athens, Greece this summer to provide these services to the top athletes from the United States. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of running in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified.
- These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,

Suzi Eisenhauer

206 North Pine

Tonkawa, OK 74653

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

THERAPY - INCIDENT TO

Re: Therapy ? Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of ?incident to? services in physician clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

During the decision-making process, please consider the following:

Incident to has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician?s professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician?s choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient. There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY incident to service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. It is imperative that physicians continue to make decisions in the best interests of the patients.

To allow only physical therapists and PT assistants, occupational therapists and OT assistants, and speech and language pathologists to provide ?incident to? services would improperly provide those groups exclusive rights to Medicare reimbursement. To mandate that only those practitioners may provide ?incident to? care in physicians? offices would improperly remove the states? right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services. As a licensed certified athletic trainer in the State of Missouri, you would be negating my professional right to treat a patient under my physician's direction.

CMS does not have the statutory authority to restrict who can and cannot provide services ?incident to? a physician office visit. In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of physical therapy services.

Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists.

Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to prevent, assess, treat and rehabilitate injuries sustained during athletic competition. In addition, dozens of athletic trainers accompanied the U.S. Olympic Team to Athens, Greece this summer to provide these services to the top athletes from the United States. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of running in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified.

As a Certified Athletic Trainer working directly in an orthopedic physician office, I obviously take great interest in this topic and feel strongly that my professional standards of practice are being insulted.

Sincerely,

Karen D. Fennell, MS, ATC/R

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

OTHER - INCIDENT TO

To whom it may concern: I am a Certified Athletic Trainer working daily in an outpatient physical therapy clinic. I am writing to formally comment on CMS not acknowledging athletic trainers as providers under the present and proposed fee schedules. Athletic trainers are appropriately educated and clinically experienced in all areas necessary for providing care to patients covered by CMS. They have the skills and knowledge to treat patients of all ages, with any number of injuries, illnesses, and pathophysiological conditions. All athletic trainers must go through a minimum of 4 years of higher education in a nationally accredited academic program, with classes that pertain to anatomy, physiology, biomechanics, therapeutic rehabilitation and modalities, nutrition, evaluation/assessment of illness and injury, etc... just to name a few. While taking these accredited classes, athletic trainers gain clinical practical experience not only in college and high school athletic settings, but also in outpatient and inpatient physical therapy clinics, hospitals, and industrial centers. Most athletic trainers also go on to receive master's and/or doctoral degrees to further their skills and to do valuable research. Clearly, then, it is not the athletic trainer's educational background that is limiting us from working with Medicare and Medicaid patients! From a financial standpoint, CMS needs to realize that recognizing athletic trainers as providers will not cost them any more money than physical therapists. Athletic trainers, like physical therapists, seek the most effective treatments in the shortest time possible. We want the patient to get better, too! By not allowing athletic trainers to treat CMS patients, 3 groups are getting hurt: the patients, athletic trainers, and CMS! Please allow athletic trainers to treat CMS patients! All of these groups will benefit!

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**GENERAL**

GENERAL

IN SUPPORT OF THIS PROVISION we offer the following arguments:

I strongly support the proposal of CMS that individuals who administer outpatient physical therapy services in physicians offices- they MUST be graduates of an accredited professional physical therapy program (or they must meet certain grand-fathering clauses or special rules for students that are foreign trained.)

Physical therapists (L.P.T.) and Physical therapist assistants (L.P.T.A) under the supervision of Physical therapists (L.P.T.) are the only qualified caregivers who have extensive theoretical and practical training to provide safe and effective physical therapy services to patients. They are licensed by the state in which they work via an extensive licensing examination.

Current educational requirements for graduation, accreditation and licensure of a Physical therapist is PhD in P.T. at an accredited professional school. It should involve medical theory and practical evaluation and treatment as well as interdisciplinary undergraduate training or degree for Pre-P.T. curriculum. Theoretical and practical exams are required in manual therapy theory and techniques, modalities- also theory and practical. The scope of training in school also extends to the outpatient, inpatient, acute, home health, orthopedic, pediatric, geriatric settings under the supervision of licensed physical therapist instructors, are among the many locations of residency that students train in.

Delivery of physical therapy practices by 'unqualified' persons can harm patients. This training is necessary to avoid improper diagnosis and treatment of patients that may cause injury or death. For example, administering massage or ultrasound to the calf of a patient who has had a history of deep vein thrombosis is contraindicated. Or the knowledge of visceral pain that can manifest as myofascial pain, and can only be treated with specific care so not to harm the patient- i.e.-heart attack pain referral in the shoulder cannot be treated through the shoulder. Properly trained licensed physical therapists differentiate and identify these problems and must determine the appropriate course of treatment through evaluation and diagnostic knowledge not attained by physical therapy 'aides' that cannot legally evaluate a patient or develop a course of treatment.

Thank you for your time and analysis.

Submitter :  Date & Time:

Organization :

Category :

Issue Areas/Comments

**GENERAL**

GENERAL

Please see the attached file.

CMS-1429-P-1118-Attach-1.doc

Stefanie Howard  
Castleton State College  
CSC Box 0942  
Castleton, VT 05735

September 15, 2004

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1429-P  
P.O. Box 8012  
Baltimore, MD 21244-8012

Re: Therapy – Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of “incident to” services in physician offices and clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

During the decision-making process, please consider the following:

- “Incident to” has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician’s professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician’s choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient.

- There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY “incident to” service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. ***It is imperative that physicians continue to make decisions in the best interests of the patients.***
- In many cases, the change to “incident to” services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient.
- This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working “incident to” the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.
- Patients who would now be referred outside of the physician’s office would incur delays of access. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Delays would hinder the patient’s recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.
- Curtailing to whom the physician can delegate “incident to” procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, who are already too busy, will take away from the physician’s ability to provide the best possible patient care.
- Athletic trainers are highly educated. ALL certified or licensed athletic trainers ***must have a bachelor’s or master’s degree*** from an accredited college or university. Foundation courses include: human physiology, human anatomy, kinesiology/biomechanics, nutrition, acute care of injury and illness, statistics and research design, and exercise physiology. Seventy (70) percent of all athletic trainers have a master’s degree or higher. This great majority of practitioners who hold advanced degrees is comparable to other health care professionals, including physical therapists, occupational therapists, registered nurses, speech therapists and many other mid-level health care practitioners. Academic programs are accredited through an independent process by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) via the Joint Review Committee on educational programs in Athletic Training (JRC-AT).
- To allow *only* physical therapists, occupational therapists, and speech and language pathologists to provide “incident to” outpatient therapy services would improperly provide these groups exclusive rights to Medicare reimbursement. To mandate that only these practitioners may provide “incident to” outpatient therapy in physicians’ offices would improperly remove the states’ right to license and regulate the allied health care professions

deemed qualified, safe and appropriate to provide health care services.

- CMS, in proposing this change, offers no evidence that there is a problem that is in need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.
- CMS does not have the statutory authority to restrict who can and cannot provide services “incident to” a physician office visit. *In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of therapy services.*
- Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists.
- Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to **prevent, assess, treat and rehabilitate** injuries sustained during athletic competition. In addition, dozens of athletic trainers will be accompanying the U.S. Olympic Team to Athens, Greece this summer to provide these services to the top athletes from the United States. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of walking in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified.
- These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,

Stefanie Howard

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

DIAGNOSTIC PSYCHOLOGICAL TESTS

I strongly support revised requirements for supervision of diagnostic psychological testing services

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**GENERAL**

GENERAL

As a physical therapist of many years, I am appalled that the proposed regulation allows fo non-physical therapists/assistants (PA, NP, CNS) to provide "therapy" for the physician practice. Why does anyone feel this is appropriate? To agree is to diminish the knowledge base and skills of every physical therapist and thus, the profession. Only physical therapists/assistants should be allowed to provide and bill for therapy services.

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

THERAPY - INCIDENT TO

Please See Attached File

Via Electronic Mail -- <http://www.cms.hhs.gov/regulations/ecomments>

Peter Koehneke  
73 Allenhurst Rd.  
Buffalo, NY 14214

September 9, 2004

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1429-P  
P.O. Box 8012  
Baltimore, MD 21244-8012

Re: Therapy – Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of “incident to” services in physician clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

During the decision-making process, please consider the following:

- Incident to has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician’s professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician’s choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient.
- There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY incident to service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. It is imperative that physicians continue to make decisions in the best interests of the patients.
- In many cases, the change to “incident to” services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient.

- This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working “incident to” the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.
- Patients who would now be referred outside of the physician’s office would incur delays of access. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Delays would hinder the patient’s recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.
- Curtailing to whom the physician can delegate “incident to” procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, who are already too busy, will take away from the physician’s ability to provide the best possible patient care.
- To allow only physical therapists and PT assistants, occupational therapists and OT assistants, and speech and language pathologists to provide “incident to” services would improperly provide those groups exclusive rights to Medicare reimbursement. To mandate that only those practitioners may provide “incident to” care in physicians’ offices would improperly remove the states’ right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.
- CMS, in proposing this change, offers no evidence that there is a problem that is need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.
- CMS does not have the statutory authority to restrict who can and cannot provide services “incident to” a physician office visit. In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of physical therapy services.
- Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists.
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- These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,

A handwritten signature in black ink, reading "Peter Koehneke". The signature is written in a cursive style with a large, looping initial "P".

Peter Koehneke

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

THERAPY - INCIDENT TO

see attachment

Scott Leslie DC, ATC  
258 West Main St.  
Babylon, NY 11702

9/09/04

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1429-P  
P.O. Box 8012  
Baltimore, MD 21244-8012

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Sincerely,

Scott Leslie DC, ATC

258 West Main St. , Babylon, NY 11702

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

THERAPY - INCIDENT TO

Maya Engelberg  
7026 Darnoch Way  
West Hills, CA 91307

September 9, 2004

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1429-P  
P.O. Box 8012  
Baltimore, MD 21244-8012

Re: Therapy ? Incident To

Dear Sir/Madam:

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There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY incident to service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a service. It is imperative that physicians continue to make decisions in the best interests of the patients.

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Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team to work with athletes to prevent, assess, treat and rehabilitate injuries sustained during competition. For CMS to even suggest that athletic trainers are unqualified to provide these services to a Medicare beneficiary who becomes injured as a result of running in a local race and goes to

their physician for treatment of that injury is outrageous and unjustified.

In summary, it is not advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely  
Maya Engelberg



Submitter : Mrs. Jennifer Robinson Date & Time: 09/09/2004 08:09:18

Organization : Mrs. Jennifer Robinson

Category : Other Health Care Professional

**Issue Areas/Comments**

**GENERAL**

GENERAL

Regarding face-to-face visits with physicians, which is required in order to consider a prescription for a prosthetic or orthotic device valid: many urgent care situations, such as a broken prosthetic limbs, must be addressed immediately. Often times physicians will simply provide a detailed prescription without seeing the patient first, if there is sufficient contact between physician and practitioner. Face-to-face visit requirements will increase the cost of healthcare, force the patient to pay another copay and will significantly delay care. Additionally, the physician will not get paid for the visit if the only reason for the visit is to get a prescription. Many amputees have no other serious health problems and would have no other reason to visit the physician other than getting a new prescription. Also, many times the physician office visit date and the date of the order cannot be within 30 days of each other. For more complicated issues or devices, it may take several visits between the physician and practitioner before it is even decided which device is needed. As an amputee and health care worker, I hope that CMS will consider these issues and provide a system that logically reduces fraud AND avoids delay in care.

Submitter : Mrs. Melinda Smith Date & Time: 09/09/2004 09:09:38

Organization : Susquehanna Health System...The Sports Medicine Ce

Category : Other Health Care Professional

**Issue Areas/Comments**

**Issues 20-29**

THERAPY - INCIDENT TO

I would like to take this opportunity to ask you to reconsider your position in regards to changes proposed in making payments to clinics, etc who utilize certified athletic trainers. The National Athletic Trainers' Association has worked since the 1950s with the AMA and Physical Therapy associations to improve the well-being and care of the physically active. To disregard the importance of certified athletic trainers by refusing payment is a grave mistake.

The trends around the world, and specifically in the United States, show an alarming increase in obesity and sedentary living. Certified athletic trainers have several domains in which they work and prevention is a big part of what we do. I would propose that more money be invested in wellness and prevention programs and less budget cuts in other areas. If an individual is healthy and strong, there will be less expenditures across the board. I would venture to say that there will be a decrease in sick time and workman's comp as well.

A certified athletic trainer brings a different focus and fresh ideas into a physician's office or clinic and can only enhance the care already being provided. I work at a local high school and have a wonderful relationship with our clinic. The doctors, physical therapists, and athletic trainers have a terrific program of communication and continuity of care. Patients who are physically active regardless of age, deserve the best treatment available and should not be forced to settle for a doctor's visit that will just have them "rest it for three weeks and see me if it is not better" approach. We provide programs that allow healing but also emphasize rehabilitation and strengthening.

Please reconsider your current budget and payments changes and put the patients first.

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

THERAPY - INCIDENT TO

Please, see attached file

September 9, 2004

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1429-P  
P.O. Box 8012  
Baltimore, MD 21244-8012

Re: Therapy – Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of “incident to” services in physician offices and clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

During the decision-making process, please consider the following:

- “Incident to” has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician’s professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician’s choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient.
- There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY “incident to” service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. ***It is imperative that physicians continue to make decisions in the best interests of the patients.***
- In many cases, the change to “incident to” services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy treatments, education, and needed immediate therapeutic interventions elsewhere, causing significant inconvenience and additional expense to the patient.

- This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working “incident to” the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.
- Patients who would now be referred outside of the physician’s office would incur delays of access. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Delays would hinder the patient’s recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.
- Curtailing to whom the physician can delegate “incident to” procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, who are already too busy, and this will take away from the physician’s ability to provide the best possible patient care.
- Athletic trainers are highly educated. ALL certified or licensed athletic trainers ***must have a bachelor’s or master’s degree*** from an accredited college or university. Foundation courses include: human physiology, human anatomy, kinesiology/biomechanics, nutrition, acute care of injury and illness, statistics and research design, and exercise physiology. Seventy (70) percent of all athletic trainers have a master’s degree or higher. This great majority of practitioners who hold advanced degrees is comparable to other health care professionals, including physical therapists, occupational therapists, registered nurses, speech therapists and many other mid-level health care practitioners. Athletic training academic programs are accredited through an independent process by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) via the Joint Review Committee on educational programs in Athletic Training (JRC-AT). CAAHEP is the same body which provides accreditation review for physician assistant education programs and other allied health care educational programs.
- To allow *only* physical therapists, occupational therapists, and speech and language pathologists to provide “incident to” outpatient therapy services would improperly provide these groups exclusive rights to Medicare reimbursement. To mandate that only these practitioners may provide “incident to” outpatient therapy in physicians’ offices would improperly remove the states’ right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.
- The therapeutic 9700 CPT codes are *NOT* provider specific and can be utilized by all qualified health care providers with the exception of provider specific evaluation and re-evaluation codes. The American Medical Association did not intend these therapeutic codes for only select providers. When used appropriately, these codes are very specific and designate specifically, what services have been provided to the patient under the care of the physician.
- CMS, in proposing this change, offers no evidence that there is a problem that is in need of fixing. By all appearances, this is being done to appease the interests of a single professional

group who would seek to establish themselves as the sole provider of therapy services.

- CMS does not have the statutory authority to restrict who can and cannot provide services “incident to” a physician office visit. ***In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of therapy services.***
- Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists.
- Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to **prevent, assess, treat and rehabilitate** injuries sustained during athletic competition. In addition, dozens of athletic trainers will be accompanying the U.S. Olympic Team to Athens, Greece this summer to provide these services to the top athletes from the United States. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of walking in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified.
- These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.
- If CMS is determined restrict the physician’s scope of professional practice and who is qualified to bill for therapeutic services under a physician for the active Medicare population, then it must also list the Certified Athletic Trainer (ATC) who has long treated this population in partnership with physicians
- In regards to PTA and OTA supervision, both should be directly supervised by their respective parties. ATCs possess a higher level of education and training in providing therapy services, consisting of an advanced degree, the minimum of a BS from an accredited educational four-year college or university, with over 70% of Certified Athletic Trainers holding a MS degree, versus PTAs and OTAs who only are required to have a two-year AA or associates degree. In addition, all ATCs are required to be directly supervised when providing incident to therapy services. PTAs and OTAs should be held to the same standard of supervision.
  - Specifically, **all three incident to health care providers and others deemed qualified by the physician** to provide therapy services (ATCs, PTAs, and OTAs) should be permitted provide incident to therapy services to Medicare patients, either under a physician or their respective supervising parties.
  - Again, *since 1991 ATCs have been considered by the American Medical Association to be a health care provider of therapy services*

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Respectfully,

Jennifer Dominick-Bayliss  
Assistant Athletic Trainer  
Trinity College  
Hartford CT 06106

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

THERAPY - INCIDENT TO

I am a sports medicine physician and work closely with both certified athletic trainers and physical therapists. I am writing in strong opposition to the proposal to limit outpatient physical therapy rehabilitation to physical therapists only. Athletic trainers are equally qualified and competent in the evaluation and treatment of musculoskeletal disorders. Limiting this service to only physical therapists would be a tremendous barrier for many patients to receive needed outpatient rehabilitation and also an unsubstantiated strike against a well respected component field in physical medicine.

Jonathan Drezner, MD

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

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Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**GENERAL**

GENERAL

Dear Dr. McClellan:

I would like to express my strong objection to the reduction in the 2005 Proposed Medicare Physician Fees for G0166, External Counterpulsation (ECP), and its impact on the payment rate for this therapy. Specifically, I wish to express my objection to the reduction in the Practice Expense RVU of 10% from 3.58 in 2004 to the 3.22 proposed for 2005. If this reduction goes into effect, I may have to stop offering ECP treatments to my patients because my costs would exceed the reimbursements for those treatments.

ECP offers a safe, non-invasive, outpatient based method of alleviating ischemia for patients who have failed usual medical therapies for treatment of disabling angina not amenable to revascularization.

External counterpulsation requires a practice investment in capital equipment, office space and disposable supplies for each treatment. In addition to these and other escalating overhead expenditures, the procedure requires a physician to provide direct supervision and a specially trained nurse or technician to evaluate and assess the patient's status before, during and after the one-hour treatment session. Patients spend approximately 75-90 minutes or longer in the practice setting per one-hour treatment session as the staff conducts assessment, patient education and post treatment evaluations. Patients receive a total of 35 one-hour treatment sessions in the usual course of therapy, although the actual amount of staff and physician time may actually be more.

Clinical benefits of ECP include reduced chest pain, reduced need for medication, increased exercise tolerance and significantly improved quality of life. Despite these documented and peer reviewed outcomes, a patient must fail multiple angioplasty or bypass procedures at costs of \$9,000 - \$25,000 per procedure vs. less than \$5,000 for ECP before qualifying for this therapy. It is very unfortunate that invasive options still receive so much attention and increased reimbursement given the success of ECP therapy.

I believe that this 2005 Proposed Rule for Medicare Physician Fee Schedule for G0166, External Counterpulsation, will limit the availability of this therapy by creating an arduous hurdle or disincentive for physicians who want to provide this to their patients. The proposed fee reduction for 2005 along with the 34% reduction for G0166 ECP in 2004 represents a cumulative reduction in reimbursement for ECP therapy of 40% over 2 years. (In contrast, cardiology practice fees are being increased on average 1.6 to 2% for 2005.)

For those of us who have made the capital investment, have signed the leases, have hired the necessary medical personnel and are devoting our time and attention to supervising the treatment process, the proposed reduction will make it even more difficult to continue to provide this important, innovative treatment.

Thank you for the opportunity to be on record through the public comment period to voice my reservations and objections with the continued reduction in physician fees for G0166. I urge you to reconsider and increase the rate for G0166.

Sincerely,

Lambert Chee, M.D., F.A.C.C.

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

THERAPY - INCIDENT TO

please see attached file

CMS-1429-P-1130-Attach-1.doc

CMS-1429-P-1130-Attach-2.doc

Kim Sawyer  
4020 Porte la Paz, #105  
San Diego, CA 92122



September 9, 2004

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1429-P  
P.O. Box 8012  
Baltimore, MD 21244-8012

Re: Therapy – Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of “incident to” services in physician clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

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  - CMS, in proposing this change, offers no evidence that there is a problem that is need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.
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Kim Sawyer  
4020 Porte la Paz, #105  
San Diego, CA 92122



September 9, 2004

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Department of Health and Human Services  
Attention: CMS-1429-P  
P.O. Box 8012  
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Kim Sawyer



Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

THERAPY - INCIDENT TO

I am wondering how many of these letters you will receive before you realize how important it is to stop this proposal for the Athletic Training Profession. I've spent many years building a highly regarded reputation in my community and among my peers that would be severely damaged, along with thousands of others, if this proposal passes legislation. Please consider our opposition as Athletic Trainers.  
PLEASE ALSO SEE ATTACHED FILE

Kelly Murry, MS, ATC/L  
8619 Constance Way  
Knoxville, TN 37923

September 9, 2004

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1429-P  
P.O. Box 8012  
Baltimore, MD 21244-8012

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8619 Constance Way

Knoxville, TN 37923

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 1-9**

GPCI

See attached letter

PRACTICE EXPENSE

See attached letter

CMS-1429-P-1132-Attach-1.doc

CMS-1429-P-1132-Attach-1.doc

September 9, 2004  
P.O. Box 2009  
Santa Cruz, Ca., 95063

Center for Medicare & Medicaid Services  
Department of Health & Human Services  
Attention CMS 1429-P  
P.O. Box 8012  
Baltimore, MD 21244-8012

File Code: CMS Code 1429-P re:GPCI

I am writing to comment on the Proposed Rules governing the Physician Fee Schedule for Calendar Year 2005 as printed in the Federal Register of August 5, 2004.

I object to the Proposed Geographic Practice Cost Indices for 2005 because they fail to correct proven inadequacies in reimbursements to localities currently categorized as "Locality 99" that exceed the 5 percent threshold (the "105% rule") over the national 1.000 average. Specifically, the new GPCIs exacerbate reimbursement deficiencies for the California counties of Santa Cruz, Sonoma, Monterey, San Diego, Sacramento, Santa Barbara and El Dorado.

In particular, the county of Santa Cruz, when broken out from Locality 99, would otherwise reflect a 1.125 percent GAF - higher than the California Localities 17 (Ventura), 18 (Los Angeles) and 26 (Orange). The boundary payment difference between Santa Cruz County and its neighboring county of Santa Clara (Locality 9) is a **whopping 25.1 percent**. Such statistics demonstrate the fallacy of the GPCI formula and demand CMS develop either exceptions to the current rules that would correct for the Santa Cruz situation or refine the formula to more accurately reflect the true cost of medical practitioners. Not to do so perpetuates an inherently unfair and discriminatory formula.

In its August 5 notice, CMS states that on the issue of payment localities "[a]ny policy that we would propose would have to apply to all States and payment localities." Such an effort is commendable and bespeaks a desire to be fair to all physicians across the nation. However, the reality is that the governing statute does not prohibit individual State fixes or individual county or locality fixes. The CMS is not constrained by law from

developing a strategy - with or without the concurrence of the state medical association - to correct the discrepancies in the reimbursement levels to California counties and I request that it do so as part of this rulemaking process.

CMS cannot postpone a solution this year as it did last year. Failure to address the GPCI/locality issue in California only grows the problems and will make fixing it all the more difficult in the future. Further, it threatens to undermine medical care to Medicare beneficiaries. Evidence from our local Medical Society shows an increasing trend toward doctors refusing to accept new Medicare patients. Many doctors are simply leaving the county to practice elsewhere, depleting the county of its medical resources. To implement the August 5 proposed rules would be counterproductive to CMS' mission to make Medicare benefits affordable and accessible to America's seniors.

I object to the Proposed Geographic Practice Cost Indices for 2005 as printed in the Federal Register of August 5, 2004. I request that CMS define a method in which it can revise the GPCIs for those California counties - especially Santa Cruz - that exceed 5 percent of the national average and begin reimbursing doctors in those counties more appropriate to their true costs.

If CMS is not willing to revise localities following the 5 percent rule, our Medical Society suggests a separate locality based on the 1996 rules in which (then) HCFA stated “ While we do not routinely revise payment areas in multiple locality states as we implement the new GPCIs, we will review the areas in multiple locality states if the newer GPCI data indicates dramatic relative cost changes among areas.” In my opinion, CMS should make Santa Cruz County a separate locality outside of Locality 99, either on the basis of the 105% rule or under the “dramatic cost” language. Thank you for your consideration of this issue and any efforts to rectify it.

Sincerely,

Alan Buchwald, M.D., FAAEM, ACMT, ABEM (TOX.)  
Staff Physician, Emergency Medicine  
Medical Director, Occupational Health Center, Dominican Hospital  
QME for the State of California  
Past President, Santa Cruz County Medical Society

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

THERAPY - INCIDENT TO

see attach file

Via Electronic Mail -- <http://www.cms.hhs.gov/regulations/ecomments>

Scott A. Frisbie, PA-C, ATC-L  
Department of Family Medicine  
200 Hawkins Drive  
Iowa City, Iowa 52242-1009

September 15, 2004

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1429-P  
P.O. Box 8012  
Baltimore, MD 21244-8012

Re: Therapy – Incident To

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- Curtailing to whom the physician can delegate “incident to” procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, who are already too busy, will take away from the physician's ability to provide the best possible patient care.
- Athletic trainers are highly educated. ALL certified or licensed athletic trainers **must have a bachelor's or master's degree** from an accredited college or university. Foundation courses include: human physiology, human anatomy, kinesiology/biomechanics, nutrition, acute care of injury and illness, statistics and research design, and exercise physiology. Seventy (70) percent of all athletic trainers have a master's degree or higher. This great majority of practitioners who hold advanced degrees is comparable to other health care professionals, including physical therapists, occupational therapists, registered nurses, speech therapists and many other mid-level health care practitioners. Academic programs are accredited through an independent process by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) via the Joint Review Committee on educational programs in Athletic Training (JRC-AT).
- To allow *only* physical therapists, occupational therapists, and speech and language pathologists to provide “incident to” outpatient therapy services would improperly provide these groups exclusive rights to Medicare reimbursement. To mandate that only these practitioners may provide “incident to” outpatient therapy in physicians' offices would improperly remove the states' right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.
- CMS, in proposing this change, offers no evidence that there is a problem that is in need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.
- CMS does not have the statutory authority to restrict who can and cannot provide services “incident to” a physician office visit. ***In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of therapy services.***
- Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists.
- Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to **prevent, assess, treat and rehabilitate** injuries sustained during athletic competition. In addition, dozens of athletic trainers will be accompanying the U.S. Olympic Team to Athens, Greece this summer to provide these services to the top athletes from the United States. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of walking in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified.
- These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,

Scott A. Frisbie, PA-C, ATC-L

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

THERAPY - INCIDENT TO

To Whom This May Concern,

I am writing to you as a student athletic trainer in the state of New Jersey. I'm aware of the current proposal Medicare Proposal Part B, which states that it would no longer reimburse a health care provider of my field in a clinical setting. I feel that this proposal is a "slap in the face" to any athletic trainer and their educational status of clinical rehabilitation. The key factor of discussion is defining what an athletic trainers role is in the health care profession. Due to the lack of awareness on exactly what an athletic trainer is or does is ignorant. Many ordinary people and including employees of the health care profession are unaware of exactly what an athletic trainer is or does.

I would like to begin with the athletic training mission statement that can be located on the official NATA website which states, "The mission of the Nation Athletic Trainers Association is to enhance the quality of health care for athletes and those engaged in physical activity, and to advance the profession of athletic training through education and research in the prevention, evaluation, management, and rehabilitation of injuries?"  
 Hmmmmmm? You might think that prevention, evaluation, management, and rehabilitation of injuries sound like something a PT or an OT would do for their career. You may also wonder what kind of a curriculum does a student athletic trainer have? Well here's a list of some specialization classes so you can compare them to those of an occupational pr physical therapist workload.

- ? Anatomy 1 & 2 w/lab
- ? Biology, Chemistry, & Physics w/lab
- ? Pathology and Evaluation of athletic injures 1 & 2 w/lab
- ? Therapeutic Exercise and Modalities w/lab
- ? Kinesiology
- ? General Pharmacology
- ? Exercise Prescription
- ? Exercise Physiology
- ? Nutrition for Fitness
- ? 1500 Hours of Clinical Experience with collegiate athletic teams
- ? Various experiences with Ortho's, Pod's, etc?

As you can see AT's are extremely educated and deal with topnotch athletes in all levels of sports such as high school, college, and the professional level. Therefore, I hope that I answered these questions briefly and informatively.

In conclusion, I strongly believe an athletic trainer or a health care provider in this field education can take their work from the playing fields or athletic training rooms to the clinical rehabilitation setting. I hope that this letter can open up a better understanding of what an athletic trainer does and possibly open up some doors as well. Thank you for your time!

Anonymous Athletic Training Student Of New Jersey

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

THERAPY - INCIDENT TO

To Whom it May Concern,

My name is Anthony Pierce, I am a certified Athletic Trainer at the University of Minnesota. I have sport responsibilities of Men's and Women's swimming and diving and Men's Gymnastics. I am very concerned with the proposed legislative change in the ability of physicians to use certified Athletic Trainers in clinical settings and bill for those services. As an Athletic Trainer in the college/ university setting I am worried that physical therapists/ occupational therapists will next say that Athletic Trainers in my setting are unqualified to provide adequate health care to student-athletes. I am completely outraged by the thought that I am not qualified to do this job. I have completed more than 7000 hours of hands on clinical experience under the direction of numerous wonderful physicians. I find it hard to believe that a new physical therapy graduate can provide any service better than I purely because they have that degree. I will tell you that our team orthopedists completely trust us in all post surgical care of student athletes. The one reason I see that physical therapists and occupational therapist may not want to attack my setting is because I do not infringe on their "territory", but I do not see how it will not stop them from attacking us next. I do not think you can imagine the chaos that this will cause. Many physical therapist are not willing to work my hours for the pay I get. I have a Masters degree from the University of Oregon, an accredited Masters curriculum by the NATA. I work under close direction from both family practice, orthopedic, psychologists, dieticians, as well in coordination with a wonderful physical therapist. I just cannot believe in any justification for referring to me as uncable of providing inadequate health care under the direction of our physicians. I challenge you to find a physician here at the University of Minnesota to speak otherwise as well. I appreciate your time.

Sincerely,

Anthony R. Pierce M.S., ATC  
Assistant Athletic Trainer  
University of Minnesota

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**GENERAL**

GENERAL

As a former student athletic trainer, I urge you to not pass this proposal. It will likely end the careers of certified athletic trainers everywhere and end the profession of athletic training. Without the ability to provide therapy, the athletic trainer is essentially just a person providing first aid. Athletic training is a unique profession, and it would be very sad to see the profession unnecessarily doomed due to this proposal.

Thank you,  
Jonathan McDonald, BSN, RN, EMT-I

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**GENERAL**

GENERAL

IN SUPPORT OF THIS PROVISION we offer the following arguments:

I strongly support the proposal of CMS that individuals who administer outpatient physical therapy services in physicians offices- they MUST be graduates of an accredited professional physical therapy program (or they must meet certain grand-fathering clauses or special rules for students that are foreign trained.)

Physical therapists (L.P.T.) and Physical therapist assistants (L.P.T.A) under the supervision of Physical therapists (L.P.T.) are the only qualified caregivers who have extensive theoretical and practical training to provide safe and effective physical therapy services to patients. They are licensed by the state in which they work via an extensive licensing examination.

Current educational requirements for graduation, accreditation and licensure of a Physical therapist is PhD in P.T. at an accredited professional school. It should involve medical theory and practical evaluation and treatment as well as interdisciplinary undergraduate training or degree for Pre-P.T. curriculum. Theoretical and practical exams are required in manual therapy theory and techniques, modalities- also theory and practical. The scope of training in school also extends to the outpatient, inpatient, acute, home health, orthopedic, pediatric, geriatric settings under the supervision of licensed physical therapist instructors, are among the many locations of residency that students train in.

Delivery of physical therapy practices by 'unqualified' persons can harm patients. This training is necessary to avoid improper diagnosis and treatment of patients that may cause injury or death. For example, administering massage or ultrasound to the calf of a patient who has had a history of deep vein thrombosis is contraindicated. Or the knowledge of visceral pain that can manifest as myofascial pain, and can only be treated with specific care so not to harm the patient- i.e.-heart attack pain referral in the shoulder cannot be treated through the shoulder. Properly trained licensed physical therapists differentiate and identify these problems and must determine the appropriate course of treatment through evaluation and diagnostic knowledge not attained by physical therapy 'aides' that cannot legally evaluate a patient or develop a course of treatment.

Thank you for your time and analysis.

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**GENERAL**

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Thank you for your time and analysis.

Submitter : June Altunel Date & Time: 09/09/2004 11:09:16

Organization : Southern Oregon Physical Therapy, Assoc. Inc.

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

IN SUPPORT OF THIS PROVISION we offer the following arguments:

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Thank you for your time and analysis.

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**GENERAL**

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Thank you for your time and analysis.

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**GENERAL**

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Thank you for your time and analysis.

Submitter : Leesa Nystrom Date & Time: 09/09/2004 11:09:13

Organization : Southern Oregon Physical Therapy, Assoc. Inc.

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

IN SUPPORT OF THIS PROVISION we offer the following arguments:

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Thank you for your time and analysis.

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**GENERAL**

GENERAL

The plan to cut medicare reimbursement for anticarcinogenic agents used in Urology offices at near or below cost will severely impair ability to care for patients with cancer of the bladder and prostate.

This will require sending patients to hospital settings for administration of these agents which will cost the medicare program significantly more as well as compromise the care of these patients.

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

THERAPY - INCIDENT TO

Please see attached file

September 9, 2004

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1429-P  
P.O. Box 8012  
Baltimore, MD 21244-8012

Re: Therapy – Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of “incident to” services in physician offices and clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

During the decision-making process, please consider the following:

- “Incident to” has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician’s professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician’s choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient.

- There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY “incident to” service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. ***It is imperative that physicians continue to make decisions in the best interests of the patients.***
- In many cases, the change to “incident to” services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient.
- This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working “incident to” the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.
- Patients who would now be referred outside of the physician’s office would incur delays of access. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Delays would hinder the patient’s recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.
- Curtailing to whom the physician can delegate “incident to” procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, who are already too busy, will take away from the physician’s ability to provide the best possible patient care.
- Athletic trainers are highly educated. ALL certified or licensed athletic trainers ***must have a bachelor’s or master’s degree*** from an accredited college or university. Foundation courses include: human physiology, human anatomy, kinesiology/biomechanics, nutrition, acute care of injury and illness, statistics and research design, and exercise physiology. Seventy (70) percent of all athletic trainers have a master’s degree or higher. This great majority of practitioners who hold advanced degrees is comparable to other health care professionals, including physical therapists, occupational therapists, registered nurses, speech therapists and many other mid-level health care practitioners. Academic programs are accredited through an independent process by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) via the Joint Review Committee on educational programs in Athletic Training (JRC-AT).
- To allow *only* physical therapists, occupational therapists, and speech and language pathologists to provide “incident to” outpatient therapy services would improperly provide these groups exclusive rights to Medicare reimbursement. To mandate that only these practitioners may provide “incident to” outpatient therapy in physicians’ offices would improperly remove the states’ right to license and regulate the allied health care professions

deemed qualified, safe and appropriate to provide health care services.

- CMS, in proposing this change, offers no evidence that there is a problem that is in need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.
- CMS does not have the statutory authority to restrict who can and cannot provide services “incident to” a physician office visit. *In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of therapy services.*
- Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists.
- Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to **prevent, assess, treat and rehabilitate** injuries sustained during athletic competition. In addition, dozens of athletic trainers will be accompanying the U.S. Olympic Team to Athens, Greece this summer to provide these services to the top athletes from the United States. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of walking in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified.
- These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,

Guido Arquilla, M.Ed., A.T.,C.

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

DIAGNOSTIC PSYCHOLOGICAL TESTS

Dear CMS:

I urge you to change your regulations to allow Psychologists to oversee and supervise psychometrist or technicians who administer psychological tests. As you may already be aware, Psychologists rather than Physicians have the educational background in test theory as well as test administration. Nearly all Psychological tests are developed by Psychologists and designed for use strictly by Psychologists with appropriate training. Psychologists are trained and bound by ethical standards to ensure that they themselves and their technicians are properly trained to administer tests. A change in your administrative code will greatly assist Psychologists in the efficient delivery of their professional healthcare services.

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

THERAPY - INCIDENT TO

Please see attached file



**DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE AND MEDICAID SERVICES  
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS**

Please note: The attachment cited in this document is not included for one of the following reasons:

1. Improper format.
2. The submitter did not follow through when attaching the document.
3. The submitter had intended to attach more than one, but not all attachments were received.
4. The type of document provided was a password-protected file. CMS was given read-only access to the document.

We cannot provide this electronic attachment to you at this time, but you would like to view any of those that are not posted on this web site, you may call CMS and schedule an appointment at **1-800-743-3951**. Those comments along with its attachment(s), that could not be posted, will be available for your viewing at that time.

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

THERAPY - INCIDENT TO

It is very disturbing that there are proposed changes that would limit the quality of healthcare management, care and specifically therapy that a medicare patient can receive.

I am an Athletic Trainer. Athletic Trainers are licensed, board certified, healthcare providers who, on a daily basis, manage and treat physically active individuals with noteworthy results- as proven with patient satisfaction research. I personally have a Master of Science degree and have 20 years of experience working with the physically active of all shapes and sizes and ages. I have worked directly with physicians in post-cardiac rehab, disease management (cardiovascular disease, cardiac post-surgery, stroke, hypertension, parkinson's, diabetes, COPD, MS, to name a few, and post surgical (TKR, THR, etc.) I also teach a Senior Fitness Instructor Certification course, I am certified by the Arthritis Foundation in ASH, PACE and WET. I am an AHA BLS and AED Instructor Trainer. I could go on. The point is that I am more than qualified to work with the older adult and there are literally hundreds of individuals that would be denied my consciensious services by the proposed limitations.

The patient's physician should be the primary gatekeeper of qualified services. Athletic Trainers are qualified. Please take the time to consider what the impact of this change would do to the healthcare environment and patient care quality.

Submitter : Mrs. Nancy Lash Date & Time: 09/10/2004 12:09:07

Organization : McLaren Regional Medical Center

Category : Other Health Care Professional

Issue Areas/Comments

**GENERAL**

GENERAL

Please see attached concerns.

**DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE AND MEDICAID SERVICES  
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS**

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Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**GENERAL**

GENERAL

September 2004

Center for Medicare & Medicaid Services  
Department of Health & Human Services  
Attention CMS 1429-P  
P.O. Box 8012  
Baltimore, MD 21244-8012

CMS Code 1429-P

We are writing to comment on the Proposed Rules governing the Physician Fee Schedule for Calendar Year 2005 as printed in the Federal Register of August 5, 2004.

Please reconsider your proposed rule. CMS committed in 1996 to updated the physician payment localities if there has been a significant change in practice costs. Santa Cruz County remains the most disadvantaged county in California. The payment differential for physician services in a county less than 20 miles from our business is over 25% greater than for services performed by local physicians. We understand that this is by far the greater such differential in the country.

This needs to stop. We are losing doctors and important specialties. Our organization cannot fathom how this is allowed to continue. We believe that Congress has delegated to CMS the responsibility to manage the payment to physicians. Further, we believe that no other county in the U.S. is in greater need of reform than our county. It is your responsibility to correct this problem. Continued postponement of this long-needed reform is ill advised and inappropriate.

Health care costs are high in our community. The economy of this county is entirely equivalent to Santa Clara County. Housing costs, wages, and benefits are equivalent. How can you support the payment differential as you propose in your rule? How can you continue to include counties such as Santa Cruz, Sacramento, and San Diego in the rural Locality 99 designation? We understand that Congress is directing to include our county in a federally sponsored redistricting in 2005. This needs to occur now.

Sincerely,

Rachel Carlton Abrams, MD

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

DIAGNOSTIC PSYCHOLOGICAL TESTS

I strongly support the CMS rule change regarding outpatient supervision of technicians by Psychologists not Physicians. I feel that our profession's unique contribution to the field of mental health is diagnostic testing. This truly separates our discipline from all others and the art of testing and interpretation is taught solely in psychology programs offering graduate degrees under supervision by professionals and as part of internship training as well. This change would be positive, and show enlightened thinking on the part of administrators. No one is more knowledgeable about testing and its uses as well as limits than psychologists.

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

DIAGNOSTIC PSYCHOLOGICAL TESTS

I support the proposed rule change to revise the current diagnostic testing rule that maintains a physician must supervise ancillary staff that administers diagnostic tests to Medicare beneficiaries.

Submitter : Miss. Andrea Silvey Date & Time: 09/10/2004 01:09:25

Organization : Ball State University - Athletic Training Student

Category : Individual

**Issue Areas/Comments**

**Issues 20-29**

THERAPY - INCIDENT TO

September 9, 2004

Ball State Athletic Training  
Ball State University  
Muncie, Indiana 47306

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1429-P  
P.O. Box 8012  
Baltimore, MD 21244-8012

Re: Therapy ? Incident To

Dear Sir/Madam:

As a future Certified Athletic Trainer (ATC) and possible future patient, I feel compelled to write this letter in opposition of proposal CMS-1429-P. I am concerned that this proposal would limit patient access to qualified health care providers of ?incident to? services, such as ATCs, in physician offices and clinics; thereby, reducing the quality of health care for physically active patients. Furthermore, limiting access to qualified health care providers will cause delays in the delivery of health care services, which in turn will increase health care costs and tax an already heavily burdened health care system.

Athletic training is the health care profession that specializes in the prevention, assessment, treatment and rehabilitation of injuries to athletes and others who are engaged in everyday physical activities. Athletic trainers are multi-skilled health care professionals who can, and are, making significant contributions to health care. Athletic trainers are highly educated and fully qualified health care providers, evident in their recognition by the American Medical Association as an allied health care profession. If this proposal would pass, it would threaten the employment of many athletic trainers who are employed as physician extenders in clinics and physician offices. Therefore this proposal threatens my future employment in those settings and the value of my degree in Athletic Training. With this type of limitation artificially placed on the provision of ?incident to? services by qualified (through accredited academic programs in athletic training, a national board examination, and state practice acts) health care providers the CMS will only add to the skyrocketing health care costs, put qualified people out of work, and reduce the overall quality of health care in the United States.

In conclusion, I believe that the CMS-1429-P proposal must be rejected in order to protect the rights (the right to choose and the right for quality care) of our patients and my right as a future health care practitioner.

Sincerely,

Andrea Silvey

Athletic Training Student at Ball State University, Muncie

Submitter : Miss. Catherine Cummings Date & Time: 09/10/2004 01:09:38

Organization : Miss. Catherine Cummings

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Via Electronic Mail -- <http://www.cms.hhs.gov/regulations/ecomments>

Catherine Cummings, M.S., ATC.  
Sports Assistant, UCSF  
26901 Patrick Ave  
Hayward, Ca 94544

September 9, 2004

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1429-P  
P.O. Box 8012  
Baltimore, MD 21244-8012

Re: Therapy ? Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of ?incident to? services in physician offices and clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

During the decision-making process, please consider the following:

? ?Incident to? has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician?s professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician?s choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient.

? There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY ?incident to? service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. It is imperative that physicians continue to make decisions in the best interests of the patients.

? In many cases, the change to ?incident to? services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere,

causing significant inconvenience and additional expense to the patient.

? This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working ?incident to? the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.

? Patients who would now be referred outside of the physician?s office would incur delays of access. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Delays would hinder the patient?s recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.

? This country is experiencing a greater number of children without medical insurance. This proposal would further complicate medical treatments, when considering more school aged children are involved in various sports each year. Many of these children, especially those in high schools, have access to a certified athletic trainer at the high school, with access to a team physician. By limiting ?incident to? health care professionals, many of the children will not have proper medical access causing either permanent physical damage, or encouraging them to drop out of sports.

? Curtailing to whom the physician can delegate ?incident to? procedures will result in physicians performing more of these routine treatments themselves.

Via Electronic Mail -- <http://www.cms.hhs.gov/regulations/ecomments>

Catherine Cummings, M.S., ATC.  
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Re: Therapy – Incident To

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I am writing to express my concern over the recent proposal that would limit providers of “incident to” services in physician offices and clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

During the decision-making process, please consider the following:

- “Incident to” has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician’s professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician’s choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient.

- There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY “incident to” service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. ***It is imperative that physicians continue to make decisions in the best interests of the patients.***
- In many cases, the change to “incident to” services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient.
- This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working “incident to” the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.
- Patients who would now be referred outside of the physician’s office would incur delays of access. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Delays would hinder the patient’s recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.
- This country is experiencing a greater number of children without medical insurance. This proposal would further complicate medical treatments, when considering more school aged children are involved in various sports each year. Many of these children, especially those in high schools, have access to a certified athletic trainer at the high school, with access to a team physician. By limiting “incident to” health care professionals, many of the children will not have proper medical access causing either permanent physical damage, or encouraging them to drop out of sports.
- Curtailing to whom the physician can delegate “incident to” procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, who are already too busy, will take away from the physician’s ability to provide the best possible patient care.
- Athletic trainers are highly educated. ALL certified or licensed athletic trainers ***must have a bachelor’s or master’s degree*** from an accredited college or university. Foundation courses include: human physiology, human anatomy, kinesiology/biomechanics, nutrition, acute care of injury and illness, statistics and research design, and exercise physiology. Seventy (70) percent of all athletic trainers have a master’s degree or higher. This great majority of practitioners who hold advanced degrees is comparable to other health care professionals, including physical therapists, occupational therapists, registered nurses, speech therapists and many other mid-level health care practitioners. Academic programs are accredited through an independent process by the Commission on Accreditation of Allied Health Education

Programs (CAAHEP) via the Joint Review Committee on educational programs in Athletic Training (JRC-AT).

- To allow *only* physical therapists, occupational therapists, and speech and language pathologists to provide “incident to” outpatient therapy services would improperly provide these groups exclusive rights to Medicare reimbursement. To mandate that only these practitioners may provide “incident to” outpatient therapy in physicians’ offices would improperly remove the states’ right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.
- CMS, in proposing this change, offers no evidence that there is a problem that is in need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.
- CMS does not have the statutory authority to restrict who can and cannot provide services “incident to” a physician office visit. *In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of therapy services.*
- Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists.
- Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to **prevent, assess, treat and rehabilitate** injuries sustained during athletic competition. In addition, dozens of athletic trainers will be accompanying the U.S. Olympic Team to Athens, Greece this summer to provide these services to the top athletes from the United States. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of walking in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified.
- These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,

Catherine Cummings, M.S., ATC

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**GENERAL**

GENERAL

Dear Sir/Madam:

I am writing for the "incident to" services being limited in physician offices and clinics. If this passes, there are many people and jobs that will be effected by this. With this loss of health care people and money, it will effect health care service, and honestly who wants to go somewhere where the service is horrible?

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

THERAPY - INCIDENT TO

I am a bit concerned about the proposed changes in the 'incident to' service that physicians will not have available to them with this proposed change.

The physician is the qualified medical professional trained to manage their patients care in what ever way they feel neccessary. Adjuct supplemental care has always been utilized by physicians to enhance their patients recovery. It has been a physician directed decision based on what is best for their patient, not what is politically manipulated by a special interest group. What is being lost in this whole discussion is the decision making ability of the physician and what is best for the patient.

As an athletic trainer, my educational preparation and skills are on the highest level. Working directly with a physician, I am entrusted to work with high level athletes and physically active individuals to help them recover from significant injuries. Under the proposed changes to 'incident to' service, a physician would not be able to utilize my expertice in his office, with any of his injured patients. This decision would limit the best options for patient care.

I am strongly objected to the proposed changes. It would be an action taken that would not be in the best interest of the patient. The decision making ability of the physician would be compromised.

Submitter : Mrs. Cathy Konkler Date & Time: 09/10/2004 03:09:00

Organization : Rehab Associates

Category : Physical Therapist

**Issue Areas/Comments**

**Issues 20-29**

OTHER - INCIDENT TO

I am a physical therapist practicing in the area of women's health and treatment of pelvic floor dysfunction. I have seen a number of individuals who were treated in a physician office with only biofeedback and electric muscle stimulation. They did not improve, and finally ended up being referred by another physician to me. They made significant improvement in physical therapy. While I use biofeedback and electrical muscle stimulation also, I do it only after a detailed internal muscle assessment so I know what the most appropriate muscle treatment is for the patient. I establish detailed goals and objectives based on this professional assessment. This is an assessment that non-skilled people in a physician office are unable to complete. Often they have no idea what the actual function of the pelvic floor muscles is, and that is why their treatment is ineffective. Modalities are an adjunct to treatment, and are effective only if used as part of a comprehensive treatment program based on known and not assumed function of the muscles. If an assessment is not completed first by a competent and knowledgeable person, the appropriate treatment plan cannot be developed, and they must rely on standard modalities and protocols which may or may not be appropriate for the patient needs. Payment for this type of service is not only a waste of Medicare money, but deceives the patient into believing that all practitioners are equally skilled and able to treat their often complex problems. I am in favor of more carefully restricting therapy services that are provided in the physician office, as the treatment currently being provided is not meeting patient needs. In the case of the individuals I have treated, Medicare ended up paying twice for therapy, before the patient received the appropriate and effective treatment.

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

MANAGING PATIENTS ON DIALYSIS

The Issue of Vein Mapping in the proposed CMS ruling needs to be revised to allow reimbursement to be specific to the procedure when it is necessary to assess veins for creation of a fistula, and not limit reimbursement to the surgeons only. Limiting reimbursement to surgeons will be counter-productive. The ruling should allow qualified practitioners to perform the procedure as long as it is necessary for the purpose of creating of a fistula. Also reimbursement for vein mapping should include either the use of contrast agents (venography) or doppler ultrasound.

CMS-1429-P-1157-Attach-1.txt

CMS-1429-P-1157-Attach-2.txt

Attachment #1157 (1 of 2)

Date: September 9, 2004

Dear CMS Representative:

I am a practicing nephrologist in Houston, Texas. Within the specialty of nephrology, I have developed expertise in management of Hemodialysis Vascular Access. I have become the Medical Director of a Dialysis Access Management Center devoted to the care of vascular access. Also, I have several publications in respectable journals on the topic of infections complications of the vascular access. One of these publications in the Journal "Kidney International" has become a reference on the subject of infections of the dialysis vascular access.

With the above background, I am an advocate of placing arteriovenous fistulas in dialysis patients. I have lectured for the National Kidney Foundation Chapter in Houston, as well as the ESRD Network of Texas on the topic of vascular access, and I am active member of the Fistula First Project in Houston.

I treat numerous end stage renal patients and I am continually concerned by the poor planning of vascular access that culminates in low percentage of arteriovenous fistulas among dialysis patients. I am constantly faced by patients who I believe could have gotten fistulas had better preoperative access planning been implemented. I therefore support the performance of venous mapping preoperatively. I believe it will be of utmost help to the vascular surgeon in order to successfully place a fistula and will be instrumental in ensuring more patients receive a fistula.

However, the current draft rule proposed by CMS limits reimbursement for this procedure to the operating surgeon. This is a major limitation to the progress in creating more fistulas. This practitioner-specific restriction should be revised to permit reimbursement for this procedure based solely on the indication and requirement that this G-code only be used for assessment for AVF placement, and not based on which specialist or facility performs the procedure. With increasing frequency, mapping is being performed well by practitioners and licensed providers other than surgeons, including: radiologists, interventional nephrologists, diagnostic vascular laboratories, and mobile diagnostic units. Limiting reimbursement for this G-code exclusively to the surgeon would serve as a barrier to increasing the AVF rate in this country, as it would prevent the majority of incident hemodialysis patients from being evaluated for AVF placement where this service is not provided by a surgeon.

Since mapping also usually requires limited assessment of the arteries, I suggest that "vein" mapping be replaced by "vessel" mapping.

Although it may not need to be addressed in the proposed G-code language,

reimbursement should not be restricted to Doppler mapping, as circumstances often require use of contrast or other mapping methods (which, incidentally, are not performed by the majority of surgeons).

Consideration should be given to replacing “graft” with “fistula” in the G-code description, as the latter would cover all autogenous procedures, whereas “graft” may confuse the issue by implying that only certain types of planned AVF procedures would qualify for reimbursement under this G-code.

I believe that these changes will result in a more proactive approach to creation fistula which will result in higher frequency of fistula, better clinical care and ultimately a lower cost to CMS. It is rare that a few simple changes will impact patient care as significantly as this rule change could. I hope that you agree with my suggestions.

Sincerely,

George M. Nassar, M.D.  
Medical Director  
Dialysis Access Management Center  
&  
Clinical Assistant Professor of Medicine  
Baylor College of Medicine  
1415 La Concha Lane  
Houston, Texas 77054  
Tel: 713-790-9080  
Fax: 713-790-0766

Comments for Venous Mapping Proposed Rule

Attachment #1157 (2 of 2)

Date: September 9, 2004

Dear CMS Representative:

I am a practicing nephrologist in Houston, Texas. Within the specialty of nephrology, I have developed expertise in management of Hemodialysis Vascular Access. I have become the Medical Director of a Dialysis Access Management Center devoted to the care of vascular access. Also, I have several publications in respectable journals on the topic of infections complications of the vascular access. One of these publications in the Journal "Kidney International" has become a reference on the subject of infections of the dialysis vascular access.

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Medical Director  
Dialysis Access Management Center  
&  
Clinical Assistant Professor of Medicine  
Baylor College of Medicine  
1415 La Concha Lane  
Houston, Texas 77054  
Tel: 713-790-9080  
Fax: 713-790-0766

Comments for Venous Mapping Proposed Rule

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

THERAPY - INCIDENT TO

Please see attached file.



**DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE AND MEDICAID SERVICES  
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS**

Please note: The attachment cited in this document is not included for one of the following reasons:

1. Improper format.
2. The submitter did not follow through when attaching the document.
3. The submitter had intended to attach more than one, but not all attachments were received.
4. The type of document provided was a password-protected file. CMS was given read-only access to the document.

We cannot provide this electronic attachment to you at this time, but you would like to view any of those that are not posted on this web site, you may call CMS and schedule an appointment at **1-800-743-3951**. Those comments along with its attachment(s), that could not be posted, will be available for your viewing at that time.

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

**THERAPY - INCIDENT TO**

To whom it may concern:

i am an athletic training student at oklahoma state university and i a writing in respect of support to allow appropriate health care personel, namely Cerfited athletic trainer(ATC), to provide "incident to" services to affected public. in turn i must assert that i vehementlay objet to any decsison that would take away that individuals'rights to slicit care and the physician's ability to precribe that care to properly educated clinicians.

Atheltic trianers are highly educated. All certified or licenced athletic trainers must have a bachelor's or master's degree froman accredited college or university. Fountaion courses inculde: human physiology, human anatomy, kinesiology/biomechanics, nutrition, acute care of injury and illness, statsitics and research design, and exercise physiology.seventy percent of all athletic trainers have a masters' degree or higher. the great majority of parctitioners who hold advanced degrees are comparable to other health care professionals , including physical therapists, occupational therapists, registered nurses, speech therapists and many other mid level health care practitioners.

As a student currently working in a Division I college in the BigIIX congerence i have the ability to work with 573 athletes in 19 sports, many of whom were conference champions as well as national champions in their respective sports this past year. i have worked side by side with members of all aspects of the health field including physicians, Physicians assistants, nurses orthopedic surgeons, and laboratory techs as a member of the sports medicine team. without certified athletic trainers to oversee the rehab process, the logical progression for injured to return to play would lack the functional and sports-specific rehabilitation that is essential.

Atheltic trainersare employed by almost every U.S.post-secondary euational instistion with an athletic program and every program and every professional sprots team in America to work with athletes to Prevent, Assess, Treat and Rehabilitate injuries sustained during athletic competition. In Addition, dozens of athletic trainers accompanied the U.S. Olympic Team to Athens, Greece this summer to provide these services to the top athletes form the united states. For Cms to even suggest that athletic Trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of walking in a local 5K race and goes to their local Physician for treatment of that injury is outrageous and unjustified.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrrent.

Sincerely

JULIE ELLENA, ATS  
Oklahoma STATE Unviersity-Stillwater  
Athletic Training Student

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

THERAPY - INCIDENT TO

Athletic trainers are highly educated throughout at accredited programs in the colleges and universities. Student athletic trainers are required to have a lot of experience at various clinical settings. We are required to take courses, which also require physicians to take, such as human anatomy, human/exercise physiology, kinesiology, nutrition, and statistics.

If the ?incident to? procedures are passed, not only will cost patients more but also will involve patients delaying of access and recovery time. There will be no benefits for patients at all, and patients will not get the best possible care. Also they will be required to pay more and be required to wait hours and hours until they get proper care.

Submitter : Miss. Date & Time: 09/10/2004 04:09:15

Organization : Miss.

Category : Individual

**Issue Areas/Comments**

**Issues 20-29**

THERAPY - INCIDENT TO

Dear Sir/Madam:

I am a senior at Southwest Missouri State University majoring in Sports Medicine and Athletic Training. I am writing to express my concern and disappointment with the recent proposal that would limit individuals who can work "incident to" physicians as well as limit providers of "incident to" services. If put into action, this will only decrease the quality of health care provided to these patients.

As a student athletic trainer I am appalled that one might think us "unqualified" to provide therapy services under the supervision of a physician. Athletic trainers are highly educated. A bachelor's or master's degree from an accredited program is needed to be a certified or licensed athletic trainer. To portray ATC's as incapable of providing therapy services comes from a lack of knowledge and education about athletic training. Studies have shown that the quality of services provided by ATC's is equal to the quality of services provided by physical therapists.

As a student working in the clinical setting I have been exposed to many aspects of the athletic trainer/physician partnership. This plan of providing health care is very effective and beneficial to the patient. If physicians cannot utilize qualified health care professionals patients will suffer delays in health care and lack immediate treatment. Physicians will be unable to provide patients with quick accessible health care-which is something we can and are successfully providing today. Physicians are CHOOSING ATC's as part of their staff in many settings including: primary care, family practice, orthopedics, physiatry, occupational medicine, etc. With this in mind, a physician has the authority to restrict who can and cannot provide services "incident to" their office, not CMS.

Intervention of the athletic trainer in health care has reduced the impact of the registered nurse shortage. Athletic training has provided health care with a 98% patient satisfaction rate as well as significantly reducing re-injury rates. ATC are employed by almost every U.S. post-secondary institution with athletics as well as professional sports teams to prevent, evaluate, treat and rehabilitate injuries.

CMS has not even offered evidence that there is a problem that needs to be fixed. This proposal does not seem to be in the best interest of the patient but instead the health care provider-CMS.

Sincerely,  
Kristen Hare  
Student Athletic Trainer/Southwest Missouri State University

Submitter :  Date & Time:

Organization :

Category :

#### Issue Areas/Comments

#### Issues 20-29

#### THERAPY - INCIDENT TO

I am writing to express my concern over the recent proposal that would limit providers of "incident to" services in physician clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

During the decision-making process, please consider the following:

"Incident to" has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician's professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician's choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient. There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY incident to service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. It is imperative that physicians continue to make decisions in the best interests of the patients.

In many cases, the change to "incident to" services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient.

This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working "incident to" the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.

Patients who would now be referred outside of the physician's office would incur delays of access. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Delays would hinder the patient's recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.

Curtailing to whom the physician can delegate "incident to" procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, who are already too busy, will take away from the physician's ability to provide the best possible patient care.

To allow only physical therapists and PT assistants, occupational therapists and OT assistants, and speech and language pathologists to provide "incident to" services would improperly provide those groups exclusive rights to Medicare reimbursement. To mandate that only those practitioners may provide "incident to" care in physicians' offices would improperly remove the states' right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.

CMS, in proposing this change, offers no evidence that there is a problem that is need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.

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#### THERAPY STANDARDS AND REQUIREMENTS

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**CMS-1429-P-1162**

? These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,

Christopher R. Fleming, LAT, ATC, EMT-I  
Sports Medicine Director  
Kapaun Mt. Carmel Catholic High School  
8506 E. Central  
Wichita, Kansas 67206

CMS-1429-P-1162-Attach-1.doc

CMS-1429-P-1162-Attach-2.doc

CMS-1429-P-1162-Attach-1.doc

CMS-1429-P-1162-Attach-2.doc

Christopher R. Fleming, LAT, ATC, EMT-I  
8506 E. Central  
Wichita, KS 67206

09-09-04

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1429-P  
P.O. Box 8012  
Baltimore, MD 21244-8012

Re: Therapy – Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of "incident to" services in physician clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

During the decision-making process, please consider the following:

- Incident to has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician's professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician's choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient.
- There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY incident to service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. It is imperative that physicians continue to make decisions in the best interests of the patients.
- In many cases, the change to "incident to" services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient.
- This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working "incident to" the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.
- Patients who would now be referred outside of the physician's office would incur delays of access. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Delays would hinder the patient's recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.
- Curtailing to whom the physician can delegate "incident to" procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, who are already too busy, will take away from the physician's ability to provide the best possible patient care.
- To allow only physical therapists and PT assistants, occupational therapists and OT assistants, and speech and language pathologists to provide "incident to" services would improperly provide those groups exclusive rights to Medicare reimbursement. To mandate that only those practitioners may provide "incident to" care in physicians' offices would improperly remove the states' right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.
- CMS, in proposing this change, offers no evidence that there is a problem that is need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.
- CMS does not have the statutory authority to restrict who can and cannot provide services "incident to" a physician office visit. In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of physical therapy services.
- Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists.
- Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to prevent, assess, treat and rehabilitate injuries sustained during athletic competition. In addition, dozens of athletic trainers have accompanied the U.S. Olympic Team to Athens, Greece this summer to provide these services to the top athletes from the United States. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of running in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified.
- These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,

Christopher R. Fleming, LAT, ATC, EMT-I

Sports Medicine Director

Kapaun Mt. Carmel Catholic High School

8506 E. Central

Wichita, Kansas 67206

Christopher R. Fleming, LAT, ATC, EMT-I  
8506 E. Central  
Wichita, KS 67206

09-09-04

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1429-P  
P.O. Box 8012  
Baltimore, MD 21244-8012

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Sports Medicine Director

Kapaun Mt. Carmel Catholic High School

8506 E. Central

Wichita, Kansas 67206

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

THERAPY - INCIDENT TO

see attached letter

September 8, 2004

Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attn: CMS-1429-P  
P.O. Box 80122  
Baltimore, MD 21244-8012

To Whom It May Concern:

I am a senior Sports Medicine and Athletic Training student at Southwest Missouri State University. I have spent the past three years and will spend the upcoming nine months studying and preparing to become a Certified Athletic Trainer (ATC). I am writing to you with concerns about the proposed change regarding "incident to" billing of outpatient physical therapy services. Not including ATCs in the list of health professionals qualified to provide outpatient physical therapy services removes a valuable asset to both the physicians providing the care as well as the patients receiving the care. In this letter, I will explain the reasons why ATCs are qualified to provide these services and the disadvantages there are by not including ATCs in the proposed changes.

I would first like to note that the athletic training profession has been recognized as an allied health care profession by the American Medical Association for over ten years. All athletic trainers must have either a bachelor's or master's degree from an accredited college or university and must pass a national certification examination in order to practice. Recent changes require that a person graduate from a curriculum based athletic training education program, accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP). The athletic training curriculum includes foundation courses in human anatomy and physiology, kinesiology/biomechanics, nutrition, acute care of injury and illness, statistics and research design, and exercise physiology. Advanced courses in the prevention, assessment, care, and rehabilitation of injuries, complete the curriculum. In addition to rigorous classroom work, athletic training students also spend many hours in different clinical settings, preparing them for their own practice. Upon completion of their coursework and graduation, athletic training students are eligible to take the national certification examination. Upon successful completion of the exam, students are able to work as an athletic trainer in a variety of settings. These settings include the traditional athletic training settings of high school, college/university, or professional athletics, as well as nontraditional settings including sports medicine clinics, physicians' offices, emergency rooms, military and industrial settings. The variety of settings shows the versatility and competency athletic trainers have working with different types of people in different types of settings, including Medicare patients in need of outpatient physical therapy services.

I also have concern with the idea that CMS can control who physicians choose to use for the care of their patients. While I agree that there should be minimum qualifications, it would be ridiculous to remove the physician's discretion to use an ATC to treat a patient just because that individual is not a "Physical Therapist" or "Occupational Therapist." The physician is educated to know which individual's service would be the best choice for each patient. If the ATC is not available to work "incident to" the physician, patients will suffer. Some patients may suffer from a greater cost of travel and/or service or an inability to receive local and immediate treatment. Delaying the initiation of treatment will delay the patient's recovery and could extend the amount of time and treatment it takes to fully recover. This will only increase the patient's as well as Medicare's total expenditures.

I appreciate you taking the time to read my comments and feelings on this issue. As a soon-to-be athletic trainer, the proposed changes worry me both personally, professionally, and for the patients. I hope that you see the benefits ATCs would provide to the Medicare system, physicians' offices, and most importantly to the patients.

Thank you,

Bethany Rogers

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**GENERAL**

GENERAL

Santa Cruz County can no longer provide basic health care to all citizens while under the burden of AREA 99 payments.

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

THERAPY - INCIDENT TO

I would ask that you not pass this bill with it's current content. The restrictions made in this bill are not founded on the true care of the patient, but more on the actions of one association to try to control a field of healthcare. I would ask that this bill not be passed or rewarded so that it would not limit who can treat a patient. The bill should passed to help provide the best healthcare to the patients.

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

THERAPY - INCIDENT TO

Please see attached file.

Jennifer Novak  
3917 St. Rt. 14  
Rootstown, Ohio 44272

Attachment to # 1166

September 10, 2004

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1429-P  
P.O. Box 8012  
Baltimore, MD 21244-8012

Re: Therapy – Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of “incident to” services in physician clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

During the decision-making process, please consider the following:

- Incident to has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician’s professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician’s choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient.
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- CMS does not have the statutory authority to restrict who can and cannot provide services “incident to” a physician office visit. In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of physical therapy services.
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- These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,

Jennifer Novak

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

**THERAPY - INCIDENT TO**

We are a small, privately owned physical therapy practice in Southwest Florida. Pelican Sports & Rehab was incorporated in 2002 and is owned and operated by Michael Willett, PT and Michael Via, MSPT. Prior to 2002, both therapists worked in outpatient physical therapy settings.

We wish to comment on the August 5 proposed rule "Therapy-Incident To" Physical Therapy Standards. We stand strongly in support of the proposed requirement that graduates of an accredited professional physical therapist program must administer physical therapy provided in physician's offices. State licensure of physical therapists was instituted to standardize requirements of knowledge and training to ensure that only qualified persons were performing this valuable medical service.

Physical therapists (or PT assistants under the supervision of physical therapists) are the only practitioners who possess the education and training to furnish physical therapy services. They receive intensive training in anatomy and physiology, have a broad understanding of the kinesiology of the body and have completed comprehensive patient care experiences. Physical therapists are professionally educated in programs accredited by the Commission on Accreditation of Physical Therapy. As of January, 2002, the minimum education requirement is a post-baccalaureate degree from an accredited education program. All programs offer at least a master's degree and most will offer the doctor of physical therapy degree by 2005. In addition, physical therapists must meet state requirements and pass the licensure boards in the states where they practice. In this way, physical therapists are fully accountable for their professional actions.

Delivery of physical therapy services by unqualified personnel is harmful to patients. Unqualified personnel are unable to obtain liability insurance, which puts their patient population at risk of financial loss as well as physical impairment.

Section 1862(a)(20) of the SSA requires that in order for a physician to bill "incident to" for physical therapy services, those services must meet the same requirements for outpatient therapy services in all settings. Therefore, the services must be performed by individuals who are graduates of accredited professional physical therapist education programs.

We appreciate the opportunity to share our views and concerns with you and thank you for taking the time to consider these comments.

Sincerely,

Michael J Willett, PT  
Michael C. Via, MSPT  
Pelican Sports & Rehabilitation  
9051 N. Tamiami Trail Suite 104  
Naples, FL 34108  
(239)591-4711

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

THERAPY - INCIDENT TO

See attached file

Daniel W. Vande Lune, M.D.  
Iowa Orthopaedic Center, P.C.  
404 Jefferson, Suite L122B  
Pella, IA 50219

Attachment to # 1168  
September 10, 2004

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1429-P  
P.O. Box 8012  
Baltimore, MD 21244-8012

Re: Therapy – Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of “incident to” services in physician offices and clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

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which would ultimately add to the medical expenditures of Medicare.

- Curtailing to whom the physician can delegate “incident to” procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, who are already too busy, will take away from the physician’s ability to provide the best possible patient care.
- Athletic trainers are highly educated. ALL certified or licensed athletic trainers **must have a bachelor’s or master’s degree** from an accredited college or university. Foundation courses include: human physiology, human anatomy, kinesiology/biomechanics, nutrition, acute care of injury and illness, statistics and research design, and exercise physiology. Seventy (70) percent of all athletic trainers have a master’s degree or higher. This great majority of practitioners who hold advanced degrees is comparable to other health care professionals, including physical therapists, occupational therapists, registered nurses, speech therapists and many other mid-level health care practitioners. Academic programs are accredited through an independent process by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) via the Joint Review Committee on educational programs in Athletic Training (JRC-AT).
- To allow *only* physical therapists, occupational therapists, and speech and language pathologists to provide “incident to” outpatient therapy services would improperly provide these groups exclusive rights to Medicare reimbursement. To mandate that only these practitioners may provide “incident to” outpatient therapy in physicians’ offices would improperly remove the states’ right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.
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Sincerely,

John Smith

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

THERAPY - INCIDENT TO

Please see attached file

Megan Harvey  
2216 Roberts Journey  
Ravenna, Oh. 44266

Attachment to # 1169  
September 10, 2004

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1429-P  
P.O. Box 8012  
Baltimore, MD 21244-8012

Re: Therapy- Incident To

Dear Sir/Madam:

I am writing in response to the "incident to" proposal. If accepted this proposal would limit the resources of physicians as well as patients by limiting the number of allied health care professionals that can treat Medicare/Medicaid patients. Because of the limited resources that this would create, costs for Medicare/Medicaid would increase.

Before you make your final decision, please consider the following:

- In the past, physicians have been able to choose which allied health care professionals are competent enough to work with their patients. If a physician feels that a certified athletic trainer is capable of working with a patient, this should not be questioned especially since he/she is legally responsible for his/her patient. The physician should be able to choose the best person for each patient, that way each patient is receiving the best care possible.
- Right now this country is suffering from a shortage of credentialed allied health care professionals. By limiting a physician's resources, patient's resources are also limited. This could cause delays in receiving treatment, increased costs of treatment because of this delay, and the patient is going to suffer longer.
- Athletic trainers have education comparable to other allied health care professionals. They must have at least a bachelor's degree in order to become certified or licensed. This degree must come from an accredited college or university. Seventy (70) percent of athletic trainers have at least their masters' degree, this puts them up at the same level as other mid-level health care professionals such as physical therapists and occupational therapists. Athletic training programs are accredited through the

Commission on Accreditation of Allied Health Education Programs  
(CAAHEP) via the Joint Review Committee on educational programs in  
Athletic Training (JRC-AT).

- Independent research has concluded that the quality of care given by athletic trainers is equal to that of physical therapists.

Sincerely,

Megan Harvey

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

THERAPY - INCIDENT TO

Limiting this would really hurt athletic trainers throughout. I feel that athletic trainers already dont get enough recognition for what they do and limited what they do further would hurt the integrity of athletic trainers

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 1-9**

SECTION 613

Concerning the proposed revision for venous mapping, we are appreciative of the new coverage offered by CMS, but restricting the payment to surgeons and disallowing payments when referral is by nephrologists is problematic. Whoever performs venous mapping should be able to bill for it.

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

THERAPY - INCIDENT TO

Please see attached file

Ryan Galloy, MA, ATC, CSCS  
Assistant Athletic Trainer  
Head Football Athletic Trainer  
Concordia University  
7400 Augusta Street  
River Forest, IL 60305

Attachment to # 1172  
September 10, 2004

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1429-P  
P.O. Box 8012  
Baltimore, MD 21244-8012

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deemed qualified, safe and appropriate to provide health care services.

- CMS, in proposing this change, offers no evidence that there is a problem that is in need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.
- CMS does not have the statutory authority to restrict who can and cannot provide services “incident to” a physician office visit. *In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of therapy services.*
- Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists.
- Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to **prevent, assess, treat and rehabilitate** injuries sustained during athletic competition. In addition, dozens of athletic trainers will be accompanying the U.S. Olympic Team to Athens, Greece this summer to provide these services to the top athletes from the United States. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of walking in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified.
- These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,

Ryan Galloy, MA, ATC, CSCS

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

DIAGNOSTIC PSYCHOLOGICAL TESTS

I support the proposed rule change regarding supervision of diagnostic psychological tests. The statements in the document regarding the training of qualified psychologists in areas of test development, standardization, and interpretation are accurate. Additionally, in the VA setting in which I work (and other hospitals and settings where I have worked in the past) the service demands on physicians are such that allowing others to perform this supervision will allow physicians to focus on areas for which they are uniquely qualified.

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

**THERAPY - INCIDENT TO**

I am writing to express my concern over the recent proposal that would limit providers of 'incident to' services in physician offices and clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the cost associated with this service and place an undue burden on the health care system.

It is imperative that physicians continue to make decisions in the best interest of the patients. In many cases, the change to 'incident to' services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient. If the physicians are no longer allowed to utilize a variety of qualified health care professionals working 'incident to' the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment. Patients who would now be referred outside of the physician's office would incur delays of access to treatment and care. These delays could hinder the patient's recovery and or increase recovery time, which would ultimately add to the medical expenditures of Medicare.

To allow only physical therapist, occupational therapist, and speech and language pathologist to provide 'incident to' outpatient therapy services would improperly provide these groups exclusive rights to Medicare reimbursement. To mandate that only these practitioners may provide 'incident to' outpatient therapy in physicians' offices would improperly remove the states' right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.

CMS, in proposing this change, offers no evidence that there is a problem that is in need of fixing. By all appearances, this is being done to appease the interest of a single professional group who would seek to establish themselves as the sole provider of therapy services. CMS does not have the statutory authority to restrict who can and cannot provide services 'incident to' a physician office visit. In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of therapy services.

Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapist.

These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is health care access deterrent.

Sincerely,

Alexander Hawkins, ATC  
Department of Homeland Security  
Federal Law Enforcement Training Center  
Charleston, S.C.

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

THERAPY - INCIDENT TO

Physical therapy is a profession not just a service provided or a list of rehabilitation CPT codes. Education for the physical therapist is lengthy and specific to examination and treatment of persons with musculoskeletal and neuromuscular impairments. The education is directed to decision-making specific to providing physical therapy care. Physicians are not educated in the physical therapy decision-making process, i.e. they use a medical (or surgical) decision-making process. Therefore, even treatment provided in a physician's office should be provided by a physical therapist in order to insure appropriate quality care.

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

THERAPY TECHNICAL REVISIONS

Please see attached files.

Randi Burt ATC  
639 Howard Rd  
Athletic Training Services  
West Point, NY 10996

Attachment to # 1176

September 10, 2004

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1429-P  
P.O. Box 8012  
Baltimore, MD 21244-8012

Re: Therapy – Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of “incident to” services in physician clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

During the decision-making process, please consider the following:

- Incident to has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician’s professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician’s choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient.
- There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY incident to service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. It is imperative that physicians continue to make decisions in the best interests of the patients.
- In many cases, the change to “incident to” services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly

accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient.

- This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working “incident to” the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.
- Patients who would now be referred outside of the physician’s office would incur delays of access. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Delays would hinder the patient’s recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.
- Curtailing to whom the physician can delegate “incident to” procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, who are already too busy, will take away from the physician’s ability to provide the best possible patient care.
- To allow only physical therapists and PT assistants, occupational therapists and OT assistants, and speech and language pathologists to provide “incident to” services would improperly provide those groups exclusive rights to Medicare reimbursement. To mandate that only those practitioners may provide “incident to” care in physicians’ offices would improperly remove the states’ right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.
- CMS, in proposing this change, offers no evidence that there is a problem that is need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.
- CMS does not have the statutory authority to restrict who can and cannot provide services “incident to” a physician office visit. In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of physical therapy services.
- Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists.
- Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to prevent, assess, treat and rehabilitate injuries sustained during athletic competition. In addition, dozens of athletic trainers will be accompanying the U.S. Olympic Team to Athens, Greece this summer to provide these services to the top athletes from the United States. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of running in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified.

- These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,

Randi Burt MA, ATC-L

Assistant Athletic Trainer

United States Military Academy

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

THERAPY - INCIDENT TO

OPTA strongly supports the proposed personnel standards for physical therapy services that are provided ?incident to? physician services in the physician?s office. OPTA has argued that interventions should be represented and reimbursed as physical therapy only when performed by a physical therapist or by a physical therapist assistant under the supervision of a physical therapist. The Association strongly opposes the use of unqualified personnel to provide services described and billed as physical therapy services.

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

ASSIGNMENT

Please see attached file

CARE PLAN OVERSIGHT

Please see attached file

DIAGNOSTIC PSYCHOLOGICAL TESTS

Please see attached file

IMPACT

Please see attached file

LOW OSMOLAR CONTRAST MEDIA

Please see attached file

MANAGING PATIENTS ON DIALYSIS

Please see attached file

TECHNICAL REVISION

Please see attached file

THERAPY - INCIDENT TO

Please see attached file

THERAPY STANDARDS AND REQUIREMENTS

Please see attached file

THERAPY TECHNICAL REVISIONS

Please see attached file

**CMS-1429-P-1178**

CMS-1429-P-1178-Attach-1.doc

CMS-1429-P-1178-Attach-1.doc

CMS-1429-P-1178-Attach-1.doc

CMS-1429-P-1178-Attach-1.doc

CMS-1429-P-1178-Attach-1.doc

CMS-1429-P-1178-Attach-1.doc

CMS-1429-P-1178-Attach-1.doc

CMS-1429-P-1178-Attach-1.doc

CMS-1429-P-1178-Attach-1.doc

Matt Kritz  
9500 Gilman Drive  
La Jolla, CA 92093

Attachment to # 1178

09/11/2004

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1429-P  
P.O. Box 8012  
Baltimore, MD 21244-8012

Re: Therapy – Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of “incident to” services in physician clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

During the decision-making process, please consider the following:

- Incident to has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician’s professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician’s choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient.
- There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY incident to service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. It is imperative that physicians continue to make decisions in the best interests of the patients.
- In many cases, the change to “incident to” services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing

- significant inconvenience and additional expense to the patient.
- This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working “incident to” the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.
  - Patients who would now be referred outside of the physician’s office would incur delays of access. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Delays would hinder the patient’s recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.
  - Curtailing to whom the physician can delegate “incident to” procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, who are already too busy, will take away from the physician’s ability to provide the best possible patient care.
  - To allow only physical therapists and PT assistants, occupational therapists and OT assistants, and speech and language pathologists to provide “incident to” services would improperly provide those groups exclusive rights to Medicare reimbursement. To mandate that only those practitioners may provide “incident to” care in physicians’ offices would improperly remove the states’ right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.
  - CMS, in proposing this change, offers no evidence that there is a problem that is need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.
  - CMS does not have the statutory authority to restrict who can and cannot provide services “incident to” a physician office visit. In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of physical therapy services.
  - Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists.
  - Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to prevent, assess, treat and rehabilitate injuries sustained during athletic competition. In addition, dozens of athletic trainers will be accompanying the U.S. Olympic Team to Athens, Greece this summer to provide these services to the top athletes from the United States. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of running in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified.

- These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,

Matt Kritz

9500 Gilman Drive

La Jolla, CA 92093

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

THERAPY - INCIDENT TO

Please see the following word document attachment concerning the inclusion of Kinesiotherapist as a recognized provider of health care services.



American Kinesiotherapy Association

P.O. Box 1390 , Hines Ill. 60141-1390

Via Electronic Mail -- <http://www.cms.hhs.gov/regulations/ecomments>

Ruth Meyer, Med, RKT  
2677 Proffit Road  
Charlottesville, VA 22911  
434-293-9987

Attachment to # 1179  
September 15, 2004

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1429-P  
P.O. Box 8012  
Baltimore, MD 21244-8012

Re: Therapy – Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of “incident to” services in physician clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service, placing an undue burden on the health care system.

During the decision-making process, please consider the following:

- Incident to has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician’s professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including registered kinesiotherapists) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician’s choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient.
- There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY “incident to” service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. ***It is imperative that physicians continue to make decisions in the best interests of the patients.***
- In many cases, the change to “incident to” services reimbursement would render the physician unable to provide his or her patients with comprehensive, accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient. If physicians are no longer allowed to utilize a variety of qualified health care professionals working “incident to” the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel

expense. Delays would hinder the patient's recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.

- To allow only physical therapists and PT assistants, occupational therapists and OT assistants, and speech and language pathologists to provide "incident to" services would improperly provide those groups exclusive rights to Medicare reimbursement. To mandate that only those practitioners may provide "incident to" care in physicians' offices would improperly remove the states' right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.
  
- CMS, in proposing this change, offers no evidence that there is a problem that is in need of fixing. In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of physical therapy services.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,

Ruth Meyer, MEd, RKT

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

DIAGNOSTIC PSYCHOLOGICAL TESTS

I am in favor of the change to facilitate better and more cost effective diagnostic and treatment planning services.

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

THERAPY - INCIDENT TO

Via Electronic Mail -- <http://www.cms.hhs.gov/regulations/ecomments>

Walter Blase Head Athletic Trainer  
Atlanta Hawks  
Centennial Tower  
101 Marietta Street NW,  
Suite 1900  
Atlanta, GA 30303

September 10, 2004

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1429-P  
P.O. Box 8012  
Baltimore, MD 21244-8012

Re: Therapy ? Incident To

Dear Sir/Madam:

I am writing in response to the recent proposal that would limit providers of ?incident to? services in physician clinics. This proposal, if adopted, would be detrimental to our health care system and would reduce the quality of care received by Medicare patients.

For the past 5 years I have worked as a certified athletic trainer for the Atlanta Hawks, providing quality health care for hundreds of elite athletes. To imply that I am not qualified to provide this same level of service to our active, senior athletes is insulting. To deny our senior population access to qualified health care providers would be unfortunate, and could cause a host of problems.

The United States is experiencing a shortage of qualified health care providers. This proposal would exacerbate this shortage by eliminating quality providers of these important services. In turn, it would reduce the quality of health care for our Medicare patients, increase the costs associated with this service and place an undue burden on the health care system.

Physicians have utilized ?incident to? to provide services to patients since the inception of the Medicare program in 1965. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician?s choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient.

There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY incident to service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. It is imperative that physicians continue to make decisions in the best interests of the patients.

Certified athletic trainers work under the direct supervision of a physician and operate as part of the total health care team. My colleagues are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to

**CMS-1429-P-1181**

work with athletes to prevent, assess, treat and rehabilitate injuries sustained during athletic competition. Dozens of athletic trainers accompanied the U.S. Olympic Team to Athens, Greece to provide these services to the top athletes from the United States. In addition, many more will provide services to participants during the upcoming Senior Olympic Games. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of running in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent. Thank you for considering my comments.

Sincerely,

Walter Blase  
Head athletic Trainer  
Atlanta Hawks

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

OTHER - INCIDENT TO

I am writing in support of the changes you have made to the rules regarding "Proposed Personnel Standards For Medicare ?Incident To? Physical Therapy Services. When unqualified personnel provide "physical therapy" services in a physicians office the patient does NOT get physical therapy. CMS and the patient pay for physical therapy but only licensed therapists can truly provide PT services. Therapists undergo 8-10 years of college, resulting in a graduate degree in order to perform PT. Secretaries, aids and other support personnel in physician offices cannot provide the same care with only hands on training from a physician. Also, it should be noted that physicians do NOT receive any training in physical therapy techniques and are not the experts in this area, making them underqualified to train and supervise an untrained individual in these techniques. I have seen patients come to my practice and tell me they received "physical therapy" at their physicians office and they didn't get any better. After a thorough PT assessment I usually find that the true musculoskeletal problem was not diagnosed in order to provide appropriate physical therapy services. Also, the services provided are usually very limited to simple pain relief and do not address correcting or fixing the problem. When these patients are seen by a qualified therapist they can get better faster with fewer visits and ultimately less expense than if they get inadequate care from an untrained person and only see a therapist when this care fails to resolve their problem. Thank you, Dr. Deb Kegelmeyer geriatric physical therapist.

Submitter :

Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

DIAGNOSTIC PSYCHOLOGICAL TESTS

I am a clinical neuropsychologist and would like to voice my very strong support for the Centers for Medicare and Medicaid Services' proposed rule change (as outlined in CMS-1429-P) that addresses the supervision of psychological and neuropsychological testing by doctoral-level psychologists.

As a clinical neuropsychologist I have completed advanced education and training in the science of brain-behavior relationships. I specialize in the application of assessment and intervention principles based on the scientific study of human behavior across the lifespan as it relates to both normal and abnormal functioning of the central nervous system. By virtue of my doctoral-level academic preparation and training, I possess specialized knowledge of psychological and neuropsychological test measurement and development, psychometric theory, specialized neuropsychological assessment techniques, statistics, and the neuropsychology of behavior (among others). Other health care providers (e.g., psychiatrists, neurologists) address these same patients' medical problems. However, our medical colleagues have not had the specialized knowledge and training (enumerated above) that is needed to safely direct the selection, administration, and interpretation of psychological and neuropsychological testing and assessment procedures in the diagnosis and care of Medicare and Medicaid patients.

My education and training uniquely qualifies me to direct test selection and to perform the interpretation of psychological and neuropsychological testing results that have been collected by non-doctoral personnel that assist with the technical aspects of psychological and neuropsychological assessments (i.e., administering and scoring the tests that I indicate). I am at all times responsible for the accuracy, validity and overall quality of all aspects of the psychological and neuropsychological assessments services that non-doctoral personnel provide under my supervision.

The current CMS requirement that neuropsychologists personally administer tests to Medicare and Medicaid patients adversely affects the overall population of Medicare and Medicaid patients because it results in neuropsychologists having less time for interviewing, test interpretation and the coordination of care. The existing requirement reduces the number of patients that each neuropsychologist can serve and results in fewer Medicare and Medicaid recipients being able to access psychological and neuropsychological services. Limited access to necessary care is already a concern in many rural and metropolitan areas. For these reasons, I strongly endorse this rule change because it will clearly benefit Medicare and Medicaid patients' by improving their access to psychological and neuropsychological assessment services.

Thank you for the opportunity to comment on this very important matter.

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

THERAPY - INCIDENT TO

I am writing to comment on the proposed legislation to limit payment to a Certified Athletic Trainer. Certified Athletic Trainers are highly educated and must continue to accrue continuing education units in order to provide the health care they are trained to perform. Please examine this legislation and amend as needed for the proper implementation while not harming those needing and providing service.

Mahalo

Tim Eakins  
Certified Athletic Trainer  
University of Hawaii at Hilo

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

DIAGNOSTIC PSYCHOLOGICAL TESTS

I am writing in favor of the CMS rule change regarding outpatient supervision of technicians. The formal didactic and experiential (e.g., internship and postdoctoral) training of psychologists greatly focuses on psychological and neuropsychological assessment. As such, psychologists obtain unique knowledge, skills, and training not afforded to other professions. It is imperative that psychologists be provided with the full rights and powers to supervise technicians who administer psychological tests due to our extensive training and experience. Having trained technicians operate under the supervision of a licensed clinical psychologist is also a service to the community because it best allocates resources (i.e., the psychologist is able to conduct therapy, consultation, or other services when testing is being administered) and allows for service to be provided to a greater number of people. As it currently stands, those technically responsible for the direction of psychological testing are physician's, the large majority of whom do not have the training or expertise to ethically interpret test results and prepare assessment reports.

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**GENERAL**

GENERAL

Support of the incident-to rule change. This rule definitely needs to be changed as proposed. Non-professionals working in a physicians office should and must be licensed to treat in that capacity. Anyone providing physical therapy services in the state of Ohio must be licensed to practice physical therapy. By continuing to allow unlicensed and unprofessional individuals practice physical therapy, you are doing an injustice to the patient receiving the less than appropriate therapy services. Not only will the patient receive palliative treatment, but most likely will require additional treatment in order to receive the same results from that of a licensed therapist; in turn driving up the cost of therapy. Moreover, medicare regulations state that in order for physical therapy to be a covered benefit; the services must require the skilled intervention of a licensed physical therapist. How can Medicare or a physician, justify the medical necessity of the therapy if it is and can be, performed by a non-licensed professional.

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

THERAPY - INCIDENT TO

We speak against this proposal. It would limit the ability of physicians to select the most appropriate health care provider to deliver therapy to their patients. According to the DOL-funded National Consortium's O\*Net OnLine occupation comparisons study, certified athletic trainers have an 8.0+ specific vocational preparation rating, identical with the rating of a physical therapist.

I realize the PTs aggressively go after and defend what they perceive as their job territory. But it is a fact that currently some 10,500 athletic trainers work in a non-athletic training room setting, such as a clinic, hospital, or doctor's office. Certified athletic trainers are just as capable of administering rehabilitative therapy in a physician's office under the direction of the physician as they are doing so in an athletic training room.

Please leave things as they are and do not limit physicians' choices for whom they wish to provide therapy services in their offices.

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**GENERAL**

GENERAL

I do not know which ISSUE number is used for "No Incident to Pay Without Proper Credentials". I would, however, like to comment on this matter. I am writing to support the proposed rule that individuals providing physical therapy services must have graduated from a physical therapy curriculum approved by the APTA and AMA Committee on Allied Health Education and Accreditation. If a physician practice bills Medicare for incident-to therapy services, the person providing the therapy should have the appropriate therapy credentials and have met the specific training standards as if the services were provided in a physical therapy office. Physical therapy professionals are more likely to provide function-focused and goal-oriented care. It would also be a conflict of interest for the physician to be providing and getting paid for physical therapy services if the physician is in the State of NY. In short, the patient benefits from physical therapy services provided by appropriately trained and credentialed therapists.

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

MANAGING PATIENTS ON DIALYSIS

I think it would be very helpful to clarify the status of physician visits to dialysis patients residing in a Skilled Nursing facility (SNF). Many SNF's are associated (connected to) with hospitals. When our patients are residents of the SNF, we usually supply dialysis treatment in the independent dialysis facility (IDF), which happens to be connected to the hospital's SNF. However, sometimes the patient is 'too ill' even to come to the outpatient IDF. If that is the case, the dialysis treatment occurs in the 'inpatient dialysis treatment area' (Call this IDTA), which the SNU contracts with to provide this service for those SNF's patients that are too sick to make it to the IDF. So, we have several MD-patient encounters that may occur and it is not clear when such visits are counted toward the monthly G codes and we require clarification.

PATIENT DIALYSED IN THE IDF

1. Patient seen by MD in the IDF during dialysis. I think this interaction should be counted in the number of visits for the G code and should not be separately billable.
2. Patient dialysed in IDF but patient is seen by MD at the SNF while not on dialysis (Should this visit count toward G code? or is it a 9931x?)

PATIENT TOO SICK. DIALYSED IN THE IDTA.

3. Patient dialysed in the IDTA and patient seen while in the IDTA (Count toward G code? I would say YES). Some may argue that this situation should not occur because, if the patient is too sick to go to the IDF, then maybe the patient should be an inpatient. Nevertheless, currently, this situation does occur and we need to address it.
4. Patient dialysed in the IDTA but patient seen in the SNF while not on dialysis (Count toward G code? I would say maybe).

Thank you

Submitter : Mrs. Jackie McIlwain Date & Time: 09/10/2004 06:09:19

Organization : The Forms Boutique

Category : Other Practitioner

**Issue Areas/Comments**

**GENERAL**

GENERAL

Mastectomy products should be excluded from face-to-face prescription requirements. Unless a woman experiences reconstruction, a mastectomy is an irreversible procedure. Based on that fact, mastectomy products are necessary throughout the life of the recipient. Medicare already has parameters in place for the dispensation of these items, which should prove sufficient. The face-to-face prescription requirement would place an undue burden on all affected Medicare beneficiaries, physicians, suppliers and MEDICARE as well. The current Medicare 90-day prescription rule has already proven to be burdensome for all those mentioned above. Medicare recipients currently resent this existing 90-day prescription requirement. Physicians are frustrated that their valuable time is taken up in the frequent writing of prescriptions for such an obvious patient need. Many physicians consistently write 'for life time use' on their prescriptions. This would seem logical, but unfortunately this logic is not accepted by Medicare. The face-to-face prescription requirement will require the recipient the inconvenience of a visit to the physician, the physician's time for the visit, and Medicare's payment for the visit - all to verify that indeed, the mastectomy is still there!

Submitter : Mrs. Kaci Kious Date & Time: 09/10/2004 06:09:50

Organization : Siouxland Sports Medicine

Category : Other Health Care Professional

**Issue Areas/Comments**

**Issues 20-29**

THERAPY - INCIDENT TO

Please see attached file.

Attachment to # 1191  
Kaci L. Kious, MS, LAT, ATC  
408 Central Ave SW  
Orange City, IA 51041

September 10, 2004

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1429-P  
P.O. Box 8012  
Baltimore, MD 21244-8012

Re: Therapy – Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of “incident to” services in physician clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

During the decision-making process, please consider the following:

- Incident to has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician’s professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician’s choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient.
- There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY incident to service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. It is imperative that physicians continue to make decisions in the best interests of the patients.
- In many cases, the change to “incident to” services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient.

- This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working “incident to” the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.
- Patients who would now be referred outside of the physician’s office would incur delays of access. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Delays would hinder the patient’s recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.
- Curtailing to whom the physician can delegate “incident to” procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, who are already too busy, will take away from the physician’s ability to provide the best possible patient care.
- To allow only physical therapists and PT assistants, occupational therapists and OT assistants, and speech and language pathologists to provide “incident to” services would improperly provide those groups exclusive rights to Medicare reimbursement. To mandate that only those practitioners may provide “incident to” care in physicians’ offices would improperly remove the states’ right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.
- CMS, in proposing this change, offers no evidence that there is a problem that is need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.
- CMS does not have the statutory authority to restrict who can and cannot provide services “incident to” a physician office visit. In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of physical therapy services.
- Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists.
- Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to prevent, assess, treat and rehabilitate injuries sustained during athletic competition. In addition, dozens of athletic trainers will be accompanying the U.S. Olympic Team to Athens, Greece this summer to provide these services to the top athletes from the United States. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of running in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified.
- These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,

Kaci L. Kious, MS, LAT, ATC  
408 Central Ave SW  
Orange City, IA 51041

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

THERAPY - INCIDENT TO

Please see attached file

Tim Auwarter, MEd, ATC  
Pardee Hospital  
800 North Justice Street  
Hendersonville, NC 28791

Attachment to # 1192  
August 16, 2004

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1429-P  
P.O. Box 8012  
Baltimore, MD 21244-8012

Re: Therapy – Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of “incident to” services in physician offices and clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

During the decision-making process, please consider the following:

- “Incident to” has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician’s professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician’s choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient.
- This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working “incident to” the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.

- Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists.
- There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY “incident to” service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. ***It is imperative that physicians continue to make decisions in the best interests of the patients.***
- In many cases, the change to “incident to” services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient.
- Patients who would now be referred outside of the physician’s office would incur delays of access. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Delays would hinder the patient’s recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.
- Curtailing to whom the physician can delegate “incident to” procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, who are already too busy, will take away from the physician’s ability to provide the best possible patient care.
- Certified athletic trainers are highly educated. Please visit [www.nata.org](http://www.nata.org) for accurate information. **ALL** certified or licensed athletic trainers ***must have a bachelor’s or master’s degree*** from an accredited college or university. Foundation courses include: human physiology, human anatomy, kinesiology/biomechanics, rehabilitation, orthopaedic assessment, nutrition, acute care of injury and illness, statistics and research design, pharmacology, and exercise physiology. Also included in the formal curriculum are clinicals and field experiences. Seventy (70) percent of all athletic trainers have a master’s degree or higher. This great majority of practitioners who hold advanced degrees is comparable to other health care professionals, including physical therapists, occupational therapists, registered nurses, speech therapists and many other mid-level health care practitioners. Academic programs are accredited through an independent process by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) via the Joint Review Committee on educational programs in Athletic Training (JRC-AT).
- To allow *only* physical therapists, occupational therapists, and speech and language pathologists to provide “incident to” outpatient therapy services would improperly provide these groups exclusive rights to Medicare reimbursement. To mandate that only these practitioners may provide “incident to” outpatient therapy in physicians’ offices would improperly remove the states’ right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services. This would also limit

the patient's **CHOICE** of allied healthcare professionals.

- CMS, in proposing this change, offers no evidence that there is a problem that is in need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services. Please research the athletic training misinformation that the American Physical Therapy Association submits to protect their interests of eliminating quality allied health care providers. You must look at accurate information to make an informed decision!
- CMS does not have the statutory authority to restrict who can and cannot provide services “incident to” a physician office visit. ***In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of therapy services.***
- Certified athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to **prevent, assess, treat and rehabilitate** injuries sustained during athletic competition. In addition, dozens of certified athletic trainers will be accompanying the U.S. Olympic Team to Athens, Greece this summer to provide these services to the top athletes from the United States. For CMS to even suggest that certified athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of walking in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified.
- Certified athletic trainers also focus on prevention of injuries. With healthcare costs placing a burden on government, employers, and citizens, CMS should take a careful look at **prevention**. Certified athletic trainers will continue to reduce the costs of healthcare through prevention, unless CMS stops them from doing so with this outrageous attempt to appease one profession's special interest.
- I find it ridiculous that the federal government hires certified athletic trainers to work in such settings as the Armed Forces and Federal Bureau of Investigation, but CMS will not recognize the certified athletic trainer as a qualified healthcare provider! In addition, take a look at hundreds, if not thousands of physical therapy clinics and hospitals that hire certified athletic trainers?
- As the country begins to explode with a more physically active elderly population what constitutes an athlete or someone who participates in physical activities. People are living longer and fuller lives and the 65+ population continues to be lead active lifestyles that include organized sports, recreational activities and generalized fitness. It only makes sense to support these individuals with the best possible healthcare practitioners that are available. Certified Athletic Trainers' have been involved in the Senior Olympics Games for years, as well as, thousands of local recreation and healthcare sponsored walking, cycling and running events for senior athletes.

- These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,

Tim Auwarter, Med, ATC  
Director of Rehab Services- Pardee Hospital

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

THERAPY - INCIDENT TO

I strongly agree with this issue. Too often I have seen the dangers of treatments provided by people who are not qualified. There are too many people who present themselves to the public as being knowledgeable in therapy, exercise or modalities when they are not. This even includes some physicians or chiropractors who may know the expected or desired results but not the actual treatment method. We need to protect the public. Thank you.

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 10-19**

THERAPY ASSISTANTS IN PRIVATE PRACTICE

I strongly support CMS's proposal to replace the requirement that physical therapist provide personal supervision (in the room) of physical therapist assistants in the physical therapist private practice office with a direct supervision requirement. This change will not diminish the quality of physical therapy services. No state requires personal (in the room) supervision of the physical therapist assistant. Physical therapist assistants are recognized under state licensure laws as having the education and training to safely and effectively deliver services without the physical therapist being in the same room as the physical therapist assistant. Physical therapist assistants are recognized practitioners under Medicare. Requiring direct supervision would be consistent with the previous Medicare supervision requirement for assistants that physical therapists in independent practice were required to meet prior to 1999. I would like to thank the Administrator for this opportunity of expression and his consideration of my comments.

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

THERAPY - INCIDENT TO

Please see the following attachment.

CMS-1429-P-1195-Attach-1.doc

CMS-1429-P-1195-Attach-2.doc

Name: Bridget Collins, M.S., RKT  
Address: 23 W 440 Spyglass Ct.  
Naperville, IL 60540

Attachment to # 1195  
September 7, 2004

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1429-P  
P.O. Box 8012  
Baltimore, MD 21244-8012

Re: Therapy – Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of “incident to” services in physician clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service, placing an undue burden on the health care system.

During the decision-making process, please consider the following:

- Incident to has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician’s professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including registered kinesiotherapists) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician’s choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient.
- There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY “incident to” service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. ***It is imperative that physicians continue to make decisions in the best interests of the patients.***
- In many cases, the change to “incident to” services reimbursement would render the physician unable to provide his or her patients with comprehensive, accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient. If physicians are no longer allowed to utilize a variety of qualified health care professionals working “incident to” the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Delays would hinder the patient’s recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.
- To allow only physical therapists and PT assistants, occupational therapists and OT assistants, and speech and language pathologists to provide “incident to” services would improperly provide those groups exclusive rights to Medicare reimbursement. To mandate that only those practitioners may provide “incident to” care in physicians’ offices would improperly remove the states’ right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.
- CMS, in proposing this change, offers no evidence that there is a problem that is in need of fixing. In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of physical therapy services.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,

Bridget Collins, M.S., RKT

Name: Bridget Collins, M.S., RKT  
Address: 23 W 440 Spyglass Ct.  
Naperville, IL 60540

Attachment 2 to # 1195  
September 7, 2004

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1429-P  
P.O. Box 8012  
Baltimore, MD 21244-8012

Re: Therapy – Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of “incident to” services in physician clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service, placing an undue burden on the health care system.

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In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,

Bridget Collins, M.S., RKT

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

**THERAPY - INCIDENT TO**

I am writing to express my concern over the recent proposal that would limit providers of "incident to" services in physician offices and clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

During the decision-making process, please consider the following:

"Incident to" has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician's professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered.

There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY "incident to" service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. It is imperative that physicians continue to make decisions in the best interests of the patients.

Athletic trainers are highly educated. ALL certified or licensed athletic trainers must have a bachelor's or master's degree from an accredited college or university. Seventy percent of all athletic trainers have a master's degree or higher. This great majority of practitioners who hold advanced degrees is comparable to other health care professionals, including physical therapists, occupational therapists, registered nurses, speech therapists and many other mid-level health care practitioners.

To allow only physical therapists, occupational therapists, and speech and language pathologists to provide "incident to" outpatient therapy services would improperly provide these groups exclusive rights to Medicare reimbursement. To mandate that only these practitioners may provide "incident to" outpatient therapy in physicians' offices would improperly remove the states' right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.

CMS does not have the statutory authority to restrict who can and cannot provide services "incident to" a physician office visit. In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of therapy services.

Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to prevent, assess, treat and rehabilitate injuries sustained during athletic competition. In addition, dozens of athletic trainers accompanied the U.S. Olympic Team to Athens, Greece this summer to provide these services to the top athletes from the United States. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of walking in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified.

These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,

Brad Floy

Submitter : Miss. Natalie Wise Date & Time: 09/10/2004 08:09:52

Organization : Cuyahoga Community College

Category : Academic

**Issue Areas/Comments**

**Issues 20-29**

THERAPY - INCIDENT TO

As a student of a Physical Therapist Assistant Program, it is difficult for me to comprehend why a PTA would not be able to practice in a private office. We are all aware that PTA's practice therapy under the direction of a PT so it is not like we are just making things up as we go along. PTA's are trained and have clinical experiences in outpatient and inpatient settings. If other facilities can utilize PTA's to perform treatment and receive reimbursement, why is it restricted in private practice. It really makes no sense to me at all. PT's and PTA's work together on a team towards the same results, why take that away from us?

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**Issues 20-29**

DIAGNOSTIC PSYCHOLOGICAL TESTS

I am a clinical neuropsychologist. The purpose of this letter is to express my very strong support for the Centers for Medicare and Medicaid Services' proposed rule change (as outlined in CMS-1429-P) that addresses the supervision of psychological and neuropsychological testing by doctoral-level psychologists.

As a clinical neuropsychologist I have completed advanced education and training in the science of brain-behavior relationships. I specialize in the application of assessment and intervention principles based on the scientific study of human behavior across the lifespan as it relates to both normal and abnormal functioning of the central nervous system. By virtue of my doctoral-level academic preparation and training, I possess specialized knowledge of psychological and neuropsychological test measurement and development, psychometric theory, specialized neuropsychological assessment techniques, statistics, and the neuropsychology of behavior (among others). Other health care providers (e.g., psychiatrists, neurologists) address these same patients' medical problems. However, our medical colleagues have not had the specialized knowledge and training (enumerated above) that is needed to safely direct the selection, administration, and interpretation of psychological and neuropsychological testing and assessment procedures in the diagnosis and care of Medicare and Medicaid patients.

My education and training uniquely qualifies me to direct test selection and to perform the interpretation of psychological and neuropsychological testing results that have been collected by non-doctoral personnel that assist with the technical aspects of psychological and neuropsychological assessments (i.e., administering and scoring the tests that I indicate). I am at all times responsible for the accuracy, validity and overall quality of all aspects of the psychological and neuropsychological assessments services that non-doctoral personnel provide under my supervision.

The current CMS requirement that neuropsychologists personally administer tests to Medicare and Medicaid patients adversely affects the overall population of Medicare and Medicaid patients because it results in neuropsychologists having less time for interviewing, test interpretation and the coordination of care. The existing requirement reduces the number of patients that each neuropsychologist can serve and results in fewer Medicare and Medicaid recipients being able to access psychological and neuropsychological services. Limited access to necessary care is already a concern in many rural and metropolitan areas. For these reasons, I strongly endorse this rule change because it will clearly benefit Medicare and Medicaid patients' by improving their access to psychological and neuropsychological assessment services.

Thank you for the opportunity to comment on this very important matter.

Submitter :  Date & Time:

Organization :

Category :

**Issue Areas/Comments**

**GENERAL**

GENERAL

Diagnostic psychological tests when given by psychology technicians should be supervised by a licensed health service provider psychologist or licensed clinical neuropsychologist. It is against the psychology licensing law in most states for a psychology technician to be supervised by anyone other than a licensed psychologist. There is also the question of the qualifications of a physician to supervise psychological testing.